Dignity Care UK Limited

Meadows Court Care Home

Inspection report

West End
Hogsthorpe
Skegness
Lincolnshire
PE24 5PA

Tel: 01754872302
Website: www.meadowscourt.net

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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
Meadows Court Care Home is a residential care home providing personal and nursing care to 13 people aged 65 and over at the time of the inspection. The service can support up to 22 people. Meadows Court Care Home is also registered to provide personal care to people in their own homes. However, due to the COVID-19 pandemic, the provider had chosen not to support people in their own homes at this time and would review this in the new year.

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

Medicines were not managed safely. People did not always receive their prescribed medicines Medicine stock was not accurate and reflective on medicine records. 'As required' medicines did not have guidance to for staff on circumstances of administration and personal information was not always recorded, such as allergies. Staff did not always receive medicine training and competencies levels were not clearly assessed. This meant people were at risk of not receiving their prescribed medicines.

Risks associated with people's care had not always been identified, assessed, mitigated and monitored effectively. Care plans did not contain sufficient information to enable staff to support people safely. Timely action was not taken and advice was not sought where there was contradicting information.
Information was not available to guide staff on how to support people with health conditions and adverse events.

Staff did not always wear their personal protective equipment (PPE) correctly which posed a risk of infection. Recent infection control audits did not identify concerns. Staff did not try and maintain social distancing and the provider did not follow national guidance relating to admissions into the service.

Quality assurance audits were carried out but were not effective in identifying shortfalls or areas for improvement. Some areas of the quality assurance audits were not completed accurately. Some staff carrying out these audits did not have specific training in that particular area. Where areas needing improvement were identified, there was no action plan in place. There was a lack of oversight from both the registered manager and provider, who had failed to identify these concerns.

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 requires improvement (20 June 2019). At this inspection enough improvement had not been made or sustained and the provider was still in breach of regulations.

Why we inspected

We carried out an unannounced comprehensive inspection of this service on 20 June 2019. A breach of legal requirements was found. The provider completed an action plan after the last inspection to show what they would do and by when to improve governance.

We undertook this inspection to look at the infection control and prevention measures the provider has in place. This was because there was a COVID-19 outbreak in the home everybody living at the home had tested positive. We widened the scope of the inspection to include the key questions of safe and well-led because we identified concerns in those key areas.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Meadows Court Care 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 medicines, risk management, infection prevent and control, and governance at this inspection. For each of these breaches you can see what action we have asked the provider to take at the end the full version of this report.

Follow up
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.

Meadows Court Care 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 CQC's response to care homes with outbreaks of coronavirus, we are conducting reviews to ensure that the Infection Prevention and Control practice was safe and the service was compliant with IPC measures. This was a targeted inspection looking at the IPC practices the provider has in place.. This inspection took place on 20 November 2020 and was unannounced.

We widened the scope of the inspection to include the key questions of safe and well-led because we identified concerns in those key areas.

Inspection team
The inspection team consisted of three inspectors. A single inspector undertook each site visit on 20 November 2020 and 30 November 2020. One inspector made telephone calls to staff.

Service and service type
Meadows Court Care 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
This inspection was announced on the day of the site visits. This was to make sure we could ensure safety for the inspection team, staff and people using the service.

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 requested information from the registered provider prior to the site visits. This related to policies and procedures, staffing, medicines, staff training and governance. We reviewed this prior to the inspection.

During the inspection-
We spoke with two people who used the service about their experience of the care provided. We spoke with six members of staff including the provider, registered manager, senior care worker, care workers and the chef.

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

Using medicines safely

● Medicines were not managed safely and line with best practice guidelines. People did not always receive their prescribed medicines from trained staff. The registered manager had failed to ensure competency of staff had been formally assessed to ensure they were safe to administer medicines to people.

● People did not always receive their prescribed medicines. One person's Medicine Administration Record (MAR) showed they did not have two different eye drops in the service for six days, which could have resulted in a deterioration in a health condition. Another person's MAR showed they did not have any pain relief in the service for six days. This person had been assessed by their doctor as needing pain relief four times a day and could have been experiencing avoidable pain and discomfort.

● Medicine Administration Records (MAR) were not always up to date with people's personal information. We found five service user MAR charts did not reflect their allergies accurately. This meant people were at risk of receiving medicine they were allergic to, which could result in serious harm. Medicine was not always booked in correctly, which meant there was no way to audit current medicine in stock for people, ensuring they received their prescribed medicines. This decreased the chance of potential error being identified in a timely way.

● The service had no record of medicines which had been ordered for people. Ordering had to be completed via telephone due to the COVID-19 pandemic restrictions. However, in the registered provider's policy it states this must be obtained in writing. Staff responsible for ordering medicines had failed to ensure a record of this had been obtained.

● People who were prescribed 'as required' medicines did not have a protocol in place to provide guidance to staff on effective administration. One person who was prescribed pain relief, when needed, was unable verbally communicate. There was no information on symptoms or behaviours staff could identify to indicate the person was in pain. This meant people were at potential risk of experiencing avoidable pain, discomfort or distress.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse

● People were at risk of avoidable harm as risks associated with their care had not always been identified, mitigated and monitored effectively. Risk assessment were not in place for equipment such as, bed rails to ensure they were used safely.

● The registered manager failed to ensure information enclosed in people's care plans was accurate and up to date to enable staff to provide safe care. For example, one person's care plan had contradicting information about their mobility needs and stated staff needed to monitor them when they were walking. However, this person was cared for in bed and could no longer walk.

● People were at risk of choking. One person was prescribed a modified diet due to a condition which affected their swallowing. They had two care plans which detailed two different textures of diet and there was no guidance available to staff on how they would achieve the prescribed consistency of food and fluids. This placed the person at an increased risk of being given the wrong diet and risk of choking.
● Weight records were not reviewed effectively, and staff were unable to demonstrate action taken where people were at high risk of malnutrition. In one person's care plan, it stated they had lost over 5kg in 6 months and had been assessed as being at high risk of being unable to maintain a healthy weight. In other parts of their care plan it stated they were not at risk. This meant the person was not supported with their weight loss and no action had been taken to try preventing further weight loss.
● People were at risk of developing pressure sores. Staff had not ensured that one person's pressure relieving mattress was correctly set up, this increased their risk of developing pressure sores.
● Most staff had received safeguarding training. However, this was out of date and there were two staff who had not received it. This meant there was a risk staff would not identify safeguarding concerns.

Preventing and controlling infection
● There had been a recent COVID-19 outbreak in the home and everyone living at the home tested positive for the infection. Despite the support they received from the local authority infection control team we still identified areas of concern where the registered manager and staff failed to work in line with national guidance.
● The provider failed to ensure people were protected from the risk of spread of infections. There were shortfalls in cleaning records to indicate cleaning did not take place in the service on 27 occasions during October and November 2020.
● Staff did not always wear Personal Protective Equipment (PPE) in line with national guidance. On two occasion, we observed staff not wearing masks appropriately. Some staff wore a visor with added gems as a decorative feature, which posed an infection risk. The registered manager wore a reusable mask, which does not offer the level of protection as the masks detailed in the guidance.
● During the lunch time period, staff sat together eating their dinner in the dining room. They did not attempt or maintain social distancing between them. This meant there was an increase of the spread of infection.
● Staff had not received training in putting on and taking off Personal Protective Equipment (PPE) safely and two members of staff had not received any formal training relating to infection control since commencing their employment. This meant there was a risk they were unaware how to manage risks to infection control appropriately.

Staffing and recruitment
● The registered manager failed to ensure staff had up to date training on how to provide safe care.
● Training records for staff showed most staff were out of date with their mandatory training. Two staff who had started employment this year had received no mandatory training. The registered manager told us this was due to the covid-19 pandemic. However, no alternative training had been sought to enable staff to provide safe and effective care to people.

Learning lessons when things go wrong
● Accidents and incidents were recorded and these were reviewed by the registered manager. However, there was no formal process in place to identify themes and trends, to reduce the risk of on going re-occurrence.

The provider failed to ensure medicines were managed safely, people's needs had been fully assessed and infection control was effective. 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 provider had ensured that staff had received appropriate pre-employment checks prior to commencing their employment to ensure suitability to work with people living in the service.
● Staffing rotas showed there were enough staff in the service to support people living there.

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 requires improvement. 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.

At the last inspection, the provider was in breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider had failed to make the improvements needed and was still in breach of the regulation.

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

- Systems and processes in place were ineffective at identifying shortfalls in the service. Where quality audits had been completed, some were undertaken by staff who had not received specific training. Others, where shortfalls were found, there were no action plans in place to resolve this.
- A medicine audit, which was conducted in November 2020 was completed by a member of staff who had not received formal medicine training. This audit was not completed accurately and did not identify concerns relating to ordering medicines, 'when required' medicines and how medicines and personal information was recorded on the Medicine Administration Record (MAR).
- The provider and registered manager failed to ensure accurate and effective oversight of quality in the service. For example, where shortfalls in staff training were identified, there was not an action plan in place to resolve this in a timely way.
- The provider failed to supply evidence of their oversight of the service. We requested information about the quality assurance audits completed by the provider, which they failed to supply to us on multiple occasions.
- Staff were not supported to return to work safely following an absence if testing positive for COVID-19. The registered manager did not work in line with the provider's policies and had not completed return to work interviews with staff to ensure their fitness to return to work
- Following the inspection, the provider and registered manager received feedback about the significant level of risk of harm to people in the service, identified during the inspection. We requested an action plan of what immediate action had been and was going to be taken to ensure risk to people was minimised and to keep people safe. We received an action plan which did not address the concerns stated in the feedback. There was no assurance that risks to people in the service had been mitigated. We took immediate action to drive improvements in the service.

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

- Although the registered manager had notified the Commission of events which took place in the service,

this was not always done in a timely way. For example, when a person left the service without staff knowledge. We raised this with the registered manager, who notified us formally.
● Information was not always shared with other agencies accurately and in a timely way. The registered manager had reported a safeguarding incident five days following an incident and did not share information which reflected the situation.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider failed to ensure their own pre-admission assessment was completed when people moved into the service, therefore, staff lacked knowledge about people's care needs to enable them to support people safely. For example, one person was diagnosed with conditions associated with their mental health. This has not been assessed and care planned to support this person effectively.
● The registered manager had failed to ensure people's mental capacity was assessed in line with the key principles of the Mental Capacity Act (2005). Where mental capacity assessment had been completed, these were not complete fully and with details around the persons details. This demonstrated people's capacity had not been fully considered in relation to their care. This had not been identified by audits.

The provider had failed to ensure there were effective quality monitoring systems and processes in place to monitor quality of the service and maintain oversight. This was a continuing breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Staff had received regular supervision to aid their development.
● People. Staff and relatives were asked for their feedback on their care and experience in the service. One relative described, "they were made to feel very welcome" in the service.
● The service worked with other healthcare professionals to ensure people received healthcare attention. For example, the community nursing team. We observed the community nurses visit people during the inspection.

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 registered provider failed to ensure people were receiving safe care and treatment.

The enforcement action we took:

We urgently imposed conditions on the registered providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider and manager failed to ensure there was effective oversight in monitoring the quality of service to prevent people from being at risk of avoidable harm.

The enforcement action we took:

We urgently imposed a condition on the registered provider registration.