Key Healthcare (St Helens) Limited

Elizabeth Court

Inspection report

New Street
Sutton
St Helens
Merseyside
WA9 3XQ

Tel: 01744821700

Date of inspection visit:
28 January 2022
08 February 2022

Date of publication:
14 March 2022

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Elizabeth Court is a residential care home providing personal and nursing care to up to 44 people. The service provides support to older people. At the time of our inspection there were 43 people using the service.

Elizabeth Court accommodates people across two separate wings, each of which has separate adapted facilities.

People's experience of using this service and what we found
Improvements were needed to ensure the registered manager was compliant with the most up to date current government guidance regarding COVID-19. This would ensure the rights of people were upheld in the event of a further outbreak at the service.

Improvements were also needed to ensure risk assessments; care plans and care monitoring records fully reflected people's needs and were subject to an appropriate system of monitoring and review. Governance systems need to be updated to reflect this.

Medicines were not always managed safely. Records didn't always accurately reflect prescriber instructions regarding prescribed creams.

People were protected from the risk of abuse. Systems were in place to monitor and appropriately report accidents and incidents to external agencies.

People received care from staff who knew them well. We observed caring interactions. Relatives also spoke highly of the care people received.

Appropriate checks on temporary (agency) and permanent members of staff were in place to ensure they were suitable for the role before working with people. Staffing levels were safely planned, which was determined by people's needs.

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 02 February 2021).

At our last inspection we recommended that the provider ensured up to date government guidance was followed in relation to infection, prevention and control. We also recommended the provider reviewed the effectiveness of their systems to monitor care records. At this inspection we found up to date systems and guidance were in place however, hadn't always been followed or implemented by the registered manager.

This meant improvements had not always been made.

Why we inspected
We undertook a targeted inspection as part of CQC's response to care homes with outbreaks of COVID-19.

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. This included checking the provider was meeting COVID-19 vaccination requirements.

We inspected and found there was a concern with how the registered manager had managed visiting during the outbreak, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to a failure to consult and involve people in decisions about visiting during the COVID-19 outbreak and in a failure to ensure provider polices and risk assessments were followed. We also found failures in accurate record keeping relating to peoples care at this inspection.

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

Follow up
We will request an action plan 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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Elizabeth Court

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. 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
This inspection was completed by one inspector. A second inspector supported the inspection by making telephone calls to relatives of people who used the service.

Service and service type
Elizabeth Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Elizabeth Court is a care home with nursing care. 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 unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to

complete a Provider Information Return (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 two people who used the service and seven relatives about their experience of the care provided. We also observed interactions between staff and people living at Elizabeth Court.

We spoke with 12 members of staff including the registered manager, nurses, senior care staff, care workers, activity workers, administration and ancillary staff.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. We also looked at a sample of temporary (agency) worker records in relation to suitability for the role and induction. 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 registered manager to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection

At our last inspection we recommended the provider ensured up to date guidance in relation to preventing and controlling infection was implemented at all times. The provider had made improvements however, these were not always implemented.

Visiting in care homes

- During a recent outbreak of COVID-19 at Elizabeth Court, the registered manager had not ensured national guidance was followed in relation to visiting. All indoor visits to the service had been stopped; unless a person was receiving care at the end of their life. This meant people had been unable to receive appropriate visits from family and friends for the duration of the outbreak.
- Risk assessments and care plans had not been developed to establish the individual needs and preferences of people. This demonstrated a lack of consultation with people about their wishes and feelings in relation to visiting during a COVID-19 outbreak.
- Where people had been unable to share their views about visiting, the registered manager had not ensured family members and significant others had been involved in any decisions. A number of relatives told us they were not aware they could have continued to visit people during the recent outbreak.

Systems had not been established to ensure suitable and appropriate care planning had been considered which reflected the individual needs and preferences of people using the service. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager responded during the inspection. We saw evidence that appropriate care plans were being developed for people. These plans included individual visiting arrangements for people in the event of a further outbreak of COVID-19.

- 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 using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider's infection prevention and control policy was up to date.

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

Care homes (Vaccinations as Condition of Deployment)

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.

The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

Assessing risk, safety monitoring and management; Using medicines safely
● There was a lack of care planning to identify people who were at a particular risk should they contract COVID-19. There was also a lack of awareness that these care plans were required.
● A number of people were prescribed creams to reduce the risk of poor skin integrity and developing pressure wounds. There were no systems in place to record the administration of prescribed creams. This meant we were not assured people were receiving all their medicines as prescribed.
● A number of people required their fluid intake to be monitored due to a physical condition or to reduce the risk of dehydration. Staff were recording the fluids offered and consumed by people, however there was a lack of knowledge by staff about how this was being monitored. Whilst we found no evidence people were dehydrated, records were not being suitably monitored to identify risks in a timely way.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. There was also a failure to maintain securely an accurate, complete and contemporaneous record in respect of each service user. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager responded during the inspection and demonstrated new systems had been introduced to improve the quality of care planning and the recording of prescribed creams.

● Other systems to assess, manage and mitigate risks were safe. For all other aspects of care, appropriate risk assessments and care plans had been developed.
● All other aspects of medication were found to be managed safely. Accurate records were maintained, medicines were stored securely. Medicines were only administered by staff who were suitably trained.
● Routine checks on the environment and equipment were up to date and certificates supported this.

Staffing and recruitment
● Staff were safely recruited. Appropriate checks had been made before being offered employment. This included checks on temporary (agency workers).
● Staffing levels were safe. We reviewed rotas. Where agency was used, workers were consistent, which helped to ensure people received continuity of care.
● Relatives also told us they felt there were sufficient staff to meet people's needs. Comments included, "Seem to be quite good. No concerns".

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

● People were protected from the risk of abuse; policies and procedures supported this. Staff had completed training and knew how and when to raise concerns.
● Provider records demonstrated referrals had been made to the local authority safeguarding team and appropriate investigations to any allegations raised were completed.
● People told us they were happy living at Elizabeth Court. One person said, "I am happy here."
● Relatives felt people were protected from the risk of abuse. Comments included, "I think the care is fine. We know [Name] is safe", "I am happy with the care [Name] is getting" and "I know [Name] is well looked after."
● Systems were in place to record accidents and incidents. They were reviewed regularly by the registered manager to look for any trends; and identify whether future incidents could be prevented.

Requires Improvement

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 our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

At our last inspection we recommended that the provider continually reviewed the effectiveness of their records monitoring systems in place. The provider had not made improvements.

● Audits and regular checks to review the quality of care being delivered were not always effective. Care plan audits had not identified a lack of care plans for people in relation to COVID-19, medicine audits had not identified the lack of record keeping for prescribed creams. There was insufficient documented oversight of people's care monitoring records.
● The registered manager failed to follow the providers polices and their own risk assessment. This meant people were unable to see their family and friends for the duration of a COVID-19 outbreak.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate risks to people's health were effectively monitored. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had notified CQC of significant events which had occurred within the service. Accurate records were maintained.
● The rating from the last inspection was displayed on the provider's website.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
● Relatives spoke positively about the care people received at Elizabeth Court and told us the they felt well informed about people's care needs. Relatives also told us the registered manager was accessible if they needed to speak directly. One relative commented, "Staff have empathy. They always contact me if there are any problems or issues which gives peace of mind. The staff are amazing."
● We also observed positive interactions between staff and people living at the service. People were treated in a caring manner by staff who knew them well.

● The registered provider also sought the views of staff, residents and relatives through questionnaires. Records were maintained of any complaints made and actions taken.

Working in partnership with others

● Information contained within care plans demonstrated the staff at Elizabeth Court worked in partnership with other agencies. We also observed external professionals visiting people during our inspection.

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 9 HSCA RA Regulations 2014 Person-centred care Systems had not been established to ensure suitable and appropriate care planning had been considered which reflected the individual needs and preferences of people using the service. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. Systems had not been established to maintain securely an accurate, complete and contemporaneous record in respect of each service user. Systems were either not in place or robust enough to demonstrate risks to people's health were effectively monitored. Regulation 17(2) (a) (b) (c)