Country Court Care Homes 3 OpCo Limited

Priory Court Care & Nursing Home

Inspection report

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Date of inspection visit:
05 July 2021
06 July 2021
12 July 2021

Date of publication:
17 September 2021

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service

Priory Court Care and Nursing Home is a nursing home, and was providing personal and nursing care to 57 people aged 65 and over at the time of the inspection. The service can support up to 71 people.

Priory Court Care and Nursing Home is a former nunnery and provides accommodation over three floors. Each floor is accessible by stairs and a lift. People living with advanced dementia are supported and accommodated on the third floor. Bedrooms provide en-suite hand washing and toilet facilities, some provide a shower, additional communal toilets, bath and shower rooms are situated throughout. Each floor has a communal dining space and lounge. People have level access to a well-stocked garden. The registered manager's office is located on the ground floor adjacent to the home's entrance and reception area. Parking is available to the front of the home.

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

Not enough staff were deployed across the service. This meant people did not always receive the care and support they needed, or they experienced a delay. Recruitment practices were not always completed in line with regulatory requirements. We made one recommendation in relation to the recruitment of staff. People were at risk of avoidable harm and abuse, this included failures to identify and investigate potential indicators of abuse. People were not always protected from the spread of COVID-19. Medicines were managed safely, we made one recommendation about guidance in relation to the application of topical creams.

Peoples' dignity and respect was not always maintained. We identified the service's tablet had been used to take undignified photographs of people. A staff member had cut one person's hair without their consent. People were not consulted about staff taking their breaks and smoking in the 'resident's garden'. People told us staff were kind and caring.

Quality checks and audits had not been used effectively to identify the concerns, errors and omissions we found during our inspection. Staff told us the registered manager was not working in the home often enough. When feedback was sought and concerns were disclosed, the registered manager did not always act to investigate concerns and improve care provision. Staff told us morale was low. Statutory notifications were submitted to the Care Quality Commission as required. Staff worked in partnership with external organisations and professionals, including the GP.

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 5 September 2020)

Why we inspected

We received concerns in relation to staffing and care provision. As a result, we undertook a focused inspection to review the key questions of safe, caring 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.
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.
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 improvement. Please see the safe, caring 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.

In response to our findings, we requested assurances about how the service planned to ensure people were kept safe. The service submitted an action plan and weekly updates. Safety measures were implemented immediately, including increased staffing levels.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Priory Court Care and 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 people receiving safe care, being placed at risk of abuse and failing to ensure people's dignity and privacy was respected. Additionally, concerns, errors and omissions we found during this inspection were not identified by the service, demonstrating a breach of good governance.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will request an action plan 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.

Special Measures

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.

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.

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, 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.

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 caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Priory Court Care & 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 two inspectors and a specialist advisor, who was a registered nurse.

Service and service type
Priory Court Care and 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.

Notice of inspection
This inspection was unannounced.

What we did before 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.

During the inspection
We spoke with nine people who used the service and three relatives about their experience of the care provided. We spoke with various members of staff including the registered manager, deputy manager, senior care workers, registered nurses, care workers, maintenance person and the chef.

We reviewed a range of records. This included peoples' care records and multiple medication records. We looked at four 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. We spoke with two professionals who regularly visit the service. An assistant inspector made telephone calls to relatives after the on-site inspection visits had been completed.

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.

Assessing risk, safety monitoring and management; Preventing and controlling infection

- People were at increased risk of harm because the service failed to ensure risks were effectively assessed, managed and monitored.
- Staff told us people were not always supported with moving and repositioning in line with their assessed needs. Comments from staff included, "People who need two staff are sometimes done by one staff; sometimes staff turn people they are not supposed to turn" and, "The carers do [provide care to] people that should have two care staff with just one of them." Records we reviewed confirmed this. The service could not know if this practice was contributing to instances of unexplained skin damage.
- People were at increased risk of malnutrition and dehydration. Records we reviewed confirmed people were losing weight, and entries used for recording food and fluid intake were inexplicably absent. This meant the service could not know if missed meals and drinks had contributed to people experiencing poor outcomes, such as weight loss.
- Care plans we reviewed contained conflicting information about levels of support people needed. For example, one person's care plan said they could eat, drink and mobilise independently. Additional assessments recorded the person was no longer mobile, required hoisting and, "Assistance and prompting at mealtime." This meant people were at risk because they may not receive the support they need.
- People were at risk of harm in the event of a fire. Information recorded in personal emergency evacuation plans (PEEPS) did not always accurately reflect the level of support people needed to evacuate safely.
- People were at risk from the spread of infection.
- The service failed to work in line with published government guidance and ensure individual COVID-19 risks were assessed. This meant people were at increased risk from the spread of COVID-19.
- When people were required to isolate to help prevent the spread of COVID-19, this was not always done safely. For example, one person who required COVID-19 testing, had not been tested in line with the provider's policy. This placed people at risk from the spread of COVID-19.
- The service failed to work in line with government guidance and consider how staff could be deployed to help minimise the spread of infection. For example, cohorting staff or allocating certain staff to specific areas of the home. This increased the risk of COVID-19 transmission.

The service failed to ensure people were protected from the risk of harm and spread of infection. Risk assessment, management and monitoring was not always effective. These failures were a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- We observed visitors wearing personal protective equipment (PPE). Relatives confirmed they needed to

test for COVID-19 prior to visiting. Comments from relatives included, "I've been twice, both times I've been in the garden. Had to have my test in the car, I wore a mask."
● In response to our concerns that staff were not supporting people in line with their assessed moving and handling needs, the operations director arranged for trainers to attend the service to check competency of relevant staff.

Staffing and recruitment
● Not enough staff were deployed across the service to meet peoples' needs.
● The registered manager used a staffing dependency tool to calculate staffing levels. However, the tool had been incorrectly populated. For example, staffing levels were being calculated based on 11 people requiring support from two care staff. However, this was incorrect; 24 people required support from two care staff.
● The staffing dependency tool did not consider how factors, such as layout and design of the premises, and the use of agency staff, impacted staffing. Additionally, there was no assessment of staff competency, skills and qualifications when allocating staff. The service could not be assured sufficient numbers of suitably qualified staff were being deployed to meet peoples' needs.
● People told us insufficient staffing levels resulted in their needs not being met, or a delay receiving support. Comments from people included, "I press the bell eight times and wait, 16 times and anything up to 100 times and I wait…It's the level of staffing that's at fault." Another person said, "The main problem is the staff; they haven't got enough staff to go around. If you want the toilet you have to wait, without the staff, what can you do?"
● Staff told us they did not always have time to support people. Comments included, "We have no time to go and help people have their drinks; that's the biggest neglect I feel" and, "I don't think people get enough to eat and drink, because when it comes to assisting, when you only have two or three staff on the floor, it's not possible to meet all the residents' needs." We observed people who were unable to mobilise, and access drinks which had been placed out of their reach. No staff were in the area to provide support.
● Staff did not always receive supervision sessions in line with the provider's policy. Supervision sessions are important; they help staff to feel supported, and promote learning and development.

Failing to ensure enough suitably qualified, experienced and supervised staff were deployed to meet peoples' needs was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● In response to our concerns, staffing levels were increased; we observed additional staff working on the final day of this inspection. The operations manager planned to review staffing daily, to ensure safe levels were maintained and implemented daily monitoring of food and fluid charts.

● The service was not consistently operating robust recruitment processes.
● Prospective staff were not always asked to provide their full employment history, in line with regulatory requirements. Three staff recruitment files we reviewed did not include a full employment history or written explanations about any gaps in employment. A full employment history is important because it helps prevent staff from hiding previous poor conduct.

We recommend the service review their recruitment processes, and make amendments to ensure checks are completed in line with regulatory requirements.

● The service completed checks with the disclosure and barring service (DBS) in relation to staff employed and working in the home. DBS checks are important because they help to prevent applicants who may be unsuitable, from working in care.

Systems and processes to safeguard people from the risk of abuse

● People were at risk of abuse because systems and processes to protect people, were not always established or used effectively.

● There was insufficient oversight of safeguarding in the home. The registered manager was not aware the service's tablet had been used to capture undignified photographs of people. We found undignified photographs of service users from 2020. The registered manager could not always confirm who had been photographed and why.

● Unexplained bruising was not always identified as a potential indicator of physical abuse. One entry into a person's care plan said, "[Person's name] was reported to have sustained a black eye, unknown cause, which has now resolved." No further action was taken. This meant if people were experiencing abuse, it may go unnoticed and unreported.

● The service did not always take a robust approach when investigating potential safeguarding concerns. For example, we raised concerns about the unexplained bruising to the person's eye. The cause was recorded as, "[Person's name] tends to rub eye on (their) own."

● One person had their hair cut by a member of care staff without their consent. The registered manager confirmed the person's hair was cut because it had become matted. However, the person and their relatives were not consulted or involved with the decision-making process.

● The local authority safeguarding team was not always alerted when unexplained bruising had occurred. This meant they were unable to investigate and identify the cause.

People were at risk of experiencing abuse and degrading treatment. This was a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● In response to our concerns about people experiencing unexplained bruising, the registered manager planned additional safeguarding training with staff and increased monitoring. The management team undertook an analysis of all adverse events and made three safeguarding alerts to the local authority safeguarding team.

● The registered manager had completed an investigation into why the person's hair had been cut without their consent and issued an apology.

● We raised six safeguarding alerts with the local authority safeguarding team.

Using medicines safely

● Medicines were managed and stored safely.

● Medicines requiring refrigeration were stored within the correct temperature range. The temperature of the medicine's fridge was monitored and recorded daily.

● Medicines records included detailed guidance for staff about peoples' preferences and information required to administer medicines safely, such as allergies. Records showed people received their medicines as prescribed.

● Staff guidance about the application of topical creams was not always sufficiently detailed. Information about when and where creams should be applied was not always documented. This meant there was a risk people may not have their creams applied as prescribed.

We recommend the service review and amend systems in relation to the application of topical creams, to ensure sufficiently detailed guidance is available for staff administering the creams.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

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 treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- People's privacy and dignity was not respected. People were not always supported to express their views.
- Staff used the service's tablet to capture undignified photographs of people. The registered manager said the photographs were taken to identify potential health concerns, such as rashes and sores. The photographs were not taken in a dignified way.
- Some undignified photographs had been taken multiple times, retained for a prolonged period and were no longer needed. Some people who were the subject of photographs had since passed away. The failure to delete these photographs meant they could be viewed by staff who had access to the tablet and were observed by members of the inspection team unnecessarily.
- We observed staff smoking on a bench in the 'resident's garden' during their breaks. People had not been consulted about staff taking their breaks and smoking in the garden. We raised this with the care manager on the morning of the first day of our inspection. No action was taken, and staff were observed smoking in the garden on the second and third days of the inspection. One person said, "Those are the staff benches, they break for a cup of tea. I presume residents can use them if they want to." People should be able to enjoy a smoke free environment.
- One person was left to sleep, overnight, in a bed with blood stains on their bedding. The bed remained blood-stained and unmade until the following afternoon when we alerted a staff member who changed it and made the bed.

People's privacy and dignity was not always maintained. People were not always asked to express their views. These failures were a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- In response to our concerns about the undignified photographs, the registered manager and senior management team commenced an investigation. All staff were scheduled to retake their dignity and respect training.
- We alerted the local authority safeguarding team to instances where people's dignity had not been protected.
- People told us that staff were kind to them, but felt there was a high staff turnover. Comments from people included, "I get on with all the staff. I don't know a lot of them because it's all new ones, they've always treated me nice" and, "The staff are very good, but for some reason they seem to come and go very

quickly."

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.

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

- Shortfalls we identified were widespread and systemic. The registered manager was not always working in the home to maintain oversight of the service.
- Checks and audits had not been used effectively to identify the errors, omissions and concerns we found during our inspection. For example, the registered manager failed to identify there were insufficient staff to meet peoples' needs. During our inspection, the registered manager said, "I'm not concerned about staffing levels in the home…we haven't reduced staffing to a level that is not safe."
- The provider failed to identify there was incomplete oversight of safeguarding and that safeguarding concerns were not always given an appropriate level of scrutiny.
- Confidential information was not always stored securely. For example, we observed peoples' medicines administration records unattended in a communal area. This meant unauthorised visitors, staff and people could access peoples' confidential information.

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

- When people raised concerns, they were not always investigated. For example, during residents' meetings, people had reported inadequate staffing levels meant their needs were not being met, or they experienced a delay receiving support. The registered manager assured people there should be enough staff to meet their needs, saying there would, "Not be much increase or change" to current staffing levels. No additional actions were taken to review staffing levels and ensure there were sufficient staff to meet peoples' needs.
- Surveys completed with staff and people also highlighted that staffing levels were not sufficient. The service responded by confirming the recruitment team had been contacted to help with recruiting staff. However, staffing levels were not reviewed and increased to ensure there were enough staff to meet peoples' needs.

Quality checks and audits were not used effectively to identify the concerns errors and omissions we found during our inspection. Feedback was not always managed in ways that improved care provision. This was a breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- After our inspection, the management team implemented an action plan to improve care provision, including implementing unannounced monitoring visits to the home.

● At the time of our inspection, the registered manager was responsible for overseeing two services. After our inspection, the registered manager told us they would no longer manage the service and a replacement would be found who could manage the home full-time. The management team also planned to recruit a registered nurse as deputy manager, to provide additional support and oversight.
● Statutory notifications were submitted in line with regulatory requirements. Statutory notifications are important as they help us to monitor and inspect the services we regulate.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff spoke about people in a person-centred way. However, insufficient staffing levels, and errors and omissions in relation to recording and care planning, meant the service could not be assured people received person-centred care that met their needs.
● Staff we spoke with said the culture of the home was not positive, and staff morale was low. Comments from staff included, "I don't enjoy my job; there is a lot of pressure on us" and, "It's quite a bad vibe….I think staff are falling out of love with their jobs."
● Staff told us they did not feel well supported and the registered manager was not visible in the home. Comments from staff included, "We are not supported by the management. We've had quite a lot of managers, we have (registered manager's name) now but (they are) not here very often" and, "We have a manager, but mostly (they are) not here."
● After our inspection, the operations director updated us that staff were reporting morale had improved in response to improvements being made. Including staff who had planned to leave, deciding to remain working in the home.

Continuous learning and improving care
● In response to our feedback, the registered manager was working with members of the senior management team to drive improvements in the home.
● After our inspection, the management team consulted with staff, relatives and people about how care provision in the home could be improved.
● At the time of our inspection, there was one activities coordinator to support the home with activities provision. After our inspection, an additional activities coordinator was appointed to ensure there were sufficient activities staff available to work with people.

Working in partnership with others
● We saw evidence staff worked in partnership with external professionals and organisations, including the GP and occupation therapists. During our inspection, we observed a physiotherapy assistant and hairdresser visiting with people in the home.
● The service had partnered with a local nursery and hosted virtual sessions where people and children could engage with activities.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager was aware of their responsibility to act honestly and apologise when things went wrong.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy and dignity was not always maintained. People were not always asked to express their views.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were at risk of experiencing abuse and degrading treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There was a failure to ensure enough suitably qualified, experienced and supervised staff were deployed to meet peoples' needs.

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
Treatment of disease, disorder or injury	The service failed to ensure people were protected from the risk of harm. Risk assessment, management and monitoring was not always effective.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Quality checks and audits were not used effectively to identify the concerns errors and omissions we found during our inspection. Feedback was not always managed in ways that improved care provision

The enforcement action we took:

Impose a condition