HC-One Limited

Knowsley Manor Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Knowsley Manor Nursing Home is a care home providing accommodation along with personal and nursing care in one purpose-built building, for up to 50 people. At the time of our inspection there were 36 people living in the home.

People's experience of using this service and what we found
The home's environment was unclean and unsafe. Infection prevention and control practices were inadequate and did not protect people from the risk of infections.

Risks to people's safety and wellbeing was not effectively managed. The risk assessment process in place for assessing and reducing risks for people had not been effectively used for several months. This meant that people's care plans were out of date, contradictory, did not contain accurate information and did not reflect the care they were receiving.

People were not receiving personal care in line with their care plans. Records showed that some people had not received a bath, shower or had their hair washed for a number of weeks.

There were not enough staff available to keep the home safe and meet people's needs in a safe and timely manner. One staff member told us, "There is never enough staff. We run around like headless chickens." One person's relative told us, "The carers are fantastic; there is just not enough of them".

People relatives told us that staff members had a kind and caring approach towards their family members; but described a staff team overstretched and under stress. One staff member told us, "Today we are one staff member down, but it is tight every day; so, it makes a big difference being one staff member down."

People's medication was not safely managed. There were significant gaps in the systems that the provider used to ensure the ongoing safety and quality of the service being provided for people. These systems had failed to pick up on and address the concerns highlighted during this inspection.

The provider had not promoted a positive culture that achieved good outcomes for people. A despondent culture that had lost sight of safe and appropriate care had been allowed to develop within the home. The home's environment had been allowed to become unsafe and unpleasant for people to live in.

During our inspection the provider arranged for additional management support at the home; alongside a review of each person's care and took steps to improve the home's environment.

During the inspection process, we raised or a whole service safeguarding with the local authority regarding the safety of medication administration and further safeguarding alerts for six people about possible neglect.

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 requires improvement (published 27 September 2019).

You can read the report from our last inspection, by selecting the 'all reports' link for Knowsley Manor Nursing Home on our website at www.cqc.org.uk.

Why we inspected
The inspection was prompted in part due to concerns received about people not receiving safe and appropriate care, safe administration of medicines, infection control and staffing. A decision was made for us to inspect and we undertook a focused inspection to review the key questions of safe and well-led only. Please see full details in the individual sections of this full report.

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.

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 requires improvement to inadequate. This is based on the findings at this inspection.

During our inspection the provider took action to mitigate the risks identified.

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 at this inspection in relation to infection prevention and control, safe environment, managing risks, sufficient numbers of staff 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.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

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.

Knowsley Manor 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 first day of the inspection was carried out by two inspectors and a medicines inspector. The second day was carried out by two inspectors.

Service and service type
Knowsley Manor Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
Both days of this inspection were unannounced.

What we did before the inspection

We reviewed all the information we held about the service since it registered with the Commission. We also obtained information about the service from the local authority and local safeguarding teams.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with a number of people about their experience at the home; however due to the nature of people's care needs these conversations were not in depth. Throughout the course of the inspection we spoke with some people's relatives, care, nursing and ancillary staff, acting managers and other senior managers within the organisation.

We reviewed a range of records. This included nine people's care records and 12 people's medication records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance and recruitment 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 requires improvement. 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

- Infection prevention and control practices were inadequate and did not protect people from the risk of infections.
- The home was unclean, unhygienic and there were unpleasant smells in parts of the home. Some people's bedclothes, curtains and bedframes were dirty and stained. People's equipment they used, such as wheelchairs and stand aids; were encrusted with a build-up of dirt.
- Frequently touched areas within the home such as door handles, push plates and door frames had stains and dirt on them. In the lounge areas the walls, floor, doors, furniture and pressure relief cushions were dirty and stained.
- Staff told us, and records showed that on many occasions there was not enough housekeeping staff on duty at the home. The housekeeping trolley being used to transport cleaning equipment was itself dirty and contained what we were told was disinfectant solution in unmarked bottles.
- There were insufficient stocks of clean bedclothes at the home, we saw people using pillows with no pillowcases, quilts with no covers and quilt covers as bedsheets.
- The PPE stations were not in convenient locations for staff members; antibacterial hand gel was not readily available. The PPE stations were dirty and disorganised with clean PPE sometimes on the floor.
- Some clinical waste bins did not contain a bag, making it difficult for staff to empty safely. Some clinical waste bins were heavily soiled. Clinical waste including used PPE was often disposed of in people's domestic bins and in other places accessible to people.
- Some people's rooms did not have a hot water supply. Staff and people's relatives told us that this had been the case for many weeks.

The provider failed to ensure that the home was clean and hygienic, and practices were followed that would prevent the spread of infections. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of our visit the provider had arranged for a contract cleaning company to assess the home and arrange for a deep clean of the premises to be scheduled for the following week. The provider also told us that they would review the deployment of housekeeping staff with immediate effect; tradesmen were at the home assessing the problem with hot water.

- Visitors wore appropriate PPE and either took or showed evidence of a rapid LFD test for COVID-19 before coming into the home. Visits to the home were recorded. We were assured that the provider was accessing testing for people using the service and staff.

Assessing risk, safety monitoring and management

● Risks to people's safety and wellbeing was not effectively managed. The risk assessment process in place for assessing and reducing risks for people had not been effectively used for several months. This meant that people's care plans were out of date, contradictory, did not contain accurate information and did not reflect the care they were receiving.

● People were not receiving personal care in line with their care plans. Records showed that some people had not received a bath, shower or had their hair washed for a number of weeks. Some people had very dirty fingernails despite care records detailing that they received daily nailcare.

● People were not receiving checks on their safety and wellbeing in line with their care plans. One person needed checking every 30 minutes when in bed to ensure their safety. On four occasions we saw that they were hanging out of their bed and alerted staff. During our visit this person's sleeping arrangements were changed. People at risk of dehydration had records in place to reduce the risk. These were not being appropriately completed to help staff ensure people drank enough fluids.

● The environment of the home was not safe and contained numerous hazards that may cause harm to people living with dementia.

● Each person had a personal emergency evacuation plan (PEEP), which should give guidance on what support a person would need during an emergency. These did not contain essential information that would be needed in an emergency.

The provider failed to ensure that risks to people were appropriately managed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our second visit the provider had arranged for an additional nurse to be at the home who was in the process of reviewing and updating people's care files and risk assessments.

Staffing and recruitment

● There were not enough staff available to meet people's needs in a safe and timely manner.

● Staff were still supporting some people to get up and ready for the day at lunchtime. Staff told us that they had not been able to help them before this time due to being short staffed. Nursing staff were also still administering people's morning medication; some of this medication was time sensitive.

● One person who had been assessed as needing one to one care and support for their safety; was often not receiving this support; due to a shortage of staff members.

● The housekeeping team was often short staffed. Records showed times when one staff member had to fulfil two or three roles. Records also showed numerous times when housekeepers had supported people to get dressed, assist them with drinks and on one occasion supported a person to use the toilet.

● On several occasions, we observed people in the lounge for a period of time with no staff members present. One staff member told us, "There is never enough staff. We run around like headless chickens." One person's relative told us, "The carers are fantastic; there is just not enough of them".

The provider failed to ensure enough members of staff were deployed to meet people's needs and keep them safe. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The recruitment of staff was safe. Pre-employment checks were carried out to assess the fitness and suitability of staff.

Using medicines safely

● People's medication was not safely managed.
● There were many times when medicines were not able to be administered as they were out of stock and people's medication was not always administered as prescribed by their doctor.
● Care plans did not always guide staff on when and how a required medicine should be given.

The provider failed to ensure that people's medicines were administered safely. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● The systems the provider had in place to have oversight of accidents and incidents did not assure us that lessons were learnt, or that people were protected from the risk of further incidents occurring.
● There were minimal improvements in the environment of the home between the first and second visits of this inspection; this was despite us raising significant concerns on day one.

Systems and processes to safeguard people from the risk of abuse
● The providers systems had not prompted or facilitated any staff member to take appropriate action and raise a safeguarding alert about known risks, or whistle blow to the local authority or other bodies about failings at the home.
● During our inspection process, we raised or prompted a whole service safeguarding with the local authority regarding the safety of medication administration and further safeguarding alerts for six people about possible neglect.

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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider had not promoted a positive culture that achieved good outcomes for people. A despondent culture that had lost sight of safe and appropriate care had been allowed to develop within the home. The home's environment had been allowed to become unsafe and unpleasant for people to live in.
- There was minimal improvement in the cleanliness and environment of the home between the first and second days of our visit. Despite us giving extensive feedback on our first day.
- When arriving at the home on both of our visits, we saw used PPE littered across the front entrance of the home and used PPE stuffed into a metal smoking bin in the car park. This was clear and visible to anybody arriving at the home; and despite us raising this remained the same on our second visit.
- During both days of our inspection, we did not see people engaging in any meaningful activities.
- People's relatives told us that staff members had a kind and caring approach towards their family members; but described a staff team overstretched and under stress. One staff member told us, "Today we are one staff member down, but it is tight every day; so, it makes a big difference being one staff member down."

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

- There was no registered manager in post at the home; there has not been a registered manager in post since August 2020. The manager that is showing as registered at the service has not been in post since 2019 and has not deregistered. The home has had a series of temporary and interim managers during this period. Staff members and people's relatives described a time of instability and multiple temporary managers at the home.
- There were significant gaps in the systems that the provider used to ensure the ongoing safety and quality of the service being provided for people. These systems had failed to pick up on and address the concerns highlighted during this inspection.
- There was evidence that there had been significant failings for some time in the safety of the service being provided for people. Despite this, appropriate action had not been taken to improve the care being provided. For example, the system for managing medication stocks, had not prompted the provider to take appropriate action and ensure this did not reoccur. A senior member of staff told us, "Oversight of our processes have not been as robust as they needed to be."
- People's care files had not been reviewed to ensure that people received safe and appropriate care and

support that met their needs.
● At times we found it difficult to obtain clear and accurate information.
● The standard of accommodation and care provided at the home had significantly deteriorated since they were last inspected.

The provider failed to appropriately assess, monitor and improve the quality and safety of the service provided for people. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection the provider arranged for additional management support at the home; alongside a review of each person's care.

Working in partnership with others
● The provider had not always ensured that appropriate information had been shared with partner organisations.

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 provider understands their responsibilities under the duty of candour regulations.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that the home was clean and hygienic, and practices were followed that would prevent the spread of infections. The provider failed to ensure that risks to people were appropriately managed. The provider failed to ensure that people's medicines were administered safely.

The enforcement action we took:

Cancellation of the registration for this location.

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 The provider failed to appropriately assess, monitor and improve the quality and safety of the service provided for people.

The enforcement action we took:

Cancellation of the registration for this location.

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 The provider failed to ensure enough members of staff were deployed to meet people's needs and keep them safe.

The enforcement action we took:

Cancellation of the registration for this location.