Manor Homes (Poulton) Limited

Cleveleys Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Cleveleys Nursing Home is registered to provide care for up to 32 older people, people living with dementia or physical disabilities. The home is situated close to Cleveleys town centre. There are bedrooms on all floors. There is a choice of communal lounges and seating areas, although people were self-isolating in their rooms, due to the COVID–19 pandemic when we visited. There were 17 people living at Cleveleys Nursing Home when we inspected.

People's experience of using this service and what we found
The service was not safe. Risks to people's health, safety and wellbeing were not consistently assessed or planned for. We reviewed seven care files and found inconsistencies or missing information in all of them. We found concerns with the cleanliness and maintenance of the environment. We observed staff not following good practice guidance around infection prevention and control including the use of Personal Protective Equipment (PPE). We found that staff had not received training in all areas required to support peoples assessed needs. We found recruitment records were not always complete and we have made a recommendation around this.

The service was not always effective. Not all staff had completed the necessary training to keep people safe. People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The service was not well-led. At this inspection we found failures in the provider's quality and assurance systems. Records relating to care and the management of the service were either incomplete, inaccurate and/or not kept up to date. This could have compromised the quality and safety of the service provided.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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

Rating at last inspection and update:
The last rating for this service was inadequate (10 March 2021) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made, and the provider was still in breach of regulations.

Why we inspected

We received concerns in relation to quality assurance, risk management and people's safety. As a result, we carried out a focused inspection to review the key questions of safe, effective 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 remained inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvements. Please see the safe, effective and well led sections of this report.
Following the inspection, the provider took immediate action to start addressing shortfalls we identified.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Cleveleys 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.

At our last inspection we identified breaches around risk management, infection prevention and control, staffing levels, staff training and leadership and oversight. We took urgent enforcement action and imposed conditions on the providers registration. During this inspection we have identified continued breaches in relation to safe care and treatment, good governance and staffing. Additionally, we have found a breach in relation to consent. 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 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.

The overall rating for this service is 'Inadequate' and the service remains 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our safe findings below.	**Inadequate**

Cleveleys 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
This inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Cleveleys 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 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. 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 one person who used the service and seven relatives about their experience of the care provided. We spoke with thirteen members of staff including the registered manager, senior care workers, care workers and domestic staff. We also spoke with the provider of the service.

We carried out observations of care to help us understand the experience of people who could not talk with us. We walked around the building to look at the environment to check on the suitability of this. We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at three 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 professionals who regularly visit the service.

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 inadequate. At this inspection this key question remains Inadequate. This meant people were not safe and protected from avoidable harm.

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

At the last inspection we found people did not always have accurate, complete and contemporaneous care records. 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.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- Risks to people's health, safety and wellbeing were not consistently assessed or planned for. We reviewed seven care files and found inconsistencies or missing information in all of them.
- One person was being given a specialist diet without input from a professional team. It was not clear in the care records what diet this person was to be given and this changed daily with staff having no guidance to follow.
- Documentation for three people who were presenting behaviours that could challenge. did not always provide clear guidance for staff to follow.
- Fire safety was not adequately risk assessed and planned for. We found the fire risk assessment was not specific and did not include all the required information. We found five fire doors that did not close properly. We referred the home to Lancashire Fire and Rescue Service and the provider took immediate action to address some of these concerns.

Preventing and controlling infection

At our last inspection we found people who used the service were placed at risk because robust procedures and practice to reduce the risk and spread of infection were not in place. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- The provider had not adequately assessed, and managed risks related to the prevention and control of infection. During the inspection, we found the environment was unclean in several areas. We found equipment in communal bathrooms to be damaged which could prevent effective decontamination.
- We found the premises were not well maintained. We saw flooring which was damaged in some areas which could prevent adequate cleaning.

● We observed staff not following good practice guidelines around the use of PPE. Additionally, staff were not always following social distancing guidelines linked to the COVID-19 pandemic.
● We viewed recent environmental audits which had not recognised the issues we found. We referred the home to the local Public Health Authority and the provider took immediate action to address some of these concerns.

Staffing and recruitment

At our last inspection we found sufficient qualified staff were not always in place and staff had not received suitable training to assist them to provide safe care. This is a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18 (Staffing).

At this inspection we found that sufficient qualified staff were in place. However, not enough improvements had been made with regards to staff training and the provider was still in breach of regulation 18.

● Staff had not been provided with training in key areas in line with people's needs. This included infection prevention and control, dementia care and dysphagia care among other areas. People at the home required support in these areas and the lack of trained staff could put people at risk of harm.

We found no evidence that people had been significantly harmed however, staff had not received suitable training to assist them to provide safe care. This is a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18 (Staffing).

● We looked at recruitment and found some recruitment files were incomplete, we found gaps in employment were not documented as explained and missing references.

We recommend that the provider reviews recruitment processes to ensure all the relevant schedule 3 information is evidenced as required.

● At this inspection we found staff were there were enough staff on duty, and they were deployed effectively to keep people safe. The service had recently developed a systematic approach to calculate the number of staff required. We spoke to the care manager about this. They confirmed they had not seen the tool but that staffing levels were determined based on people's individual needs and in line with best practice guidelines.

Learning lessons when things go wrong

At our last inspection we recommended the provider develop systems for reflecting on and evaluating accidents, incidents and near misses.

● The provider was unable to evidence that lessons were learnt following accidents and incidents. We viewed the records of accident and incidents which did not always include details of any lessons learned. The documented action taken following the incidents was brief, when we discussed some of the incidents with the management team, they were not able to assure us of the actions they had taken in response to the accident or incident.

We found no evidence that people had been significantly harmed however, systems were either not in place or robust enough to demonstrate lessons were learnt following accidents and incidents. 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.

Using medicines safely
● Quantities of medicines were not always recorded; we could not be assured people were receiving their medicines as prescribed.
● The issues we found with medicines practices made it difficult or impossible to audit the safe administration of medicines.

We found no evidence that people had been significantly harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had procedures to support the safe administration of medicines. Staff who administered people's medicines had completed appropriate training.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Staff were not always working within the principles of the MCA. Staff had not completed capacity tests to check whether people could make specific decisions or required decisions to be made in their best interest where they lacked capacity. There was a lack of MCA training which impacted on staff knowledge and understanding of the principles.
- Restrictive practices were not well managed. These restrictions had not been risk assessed or care planned, and it was not evidenced if any other less restrictive options had been considered.
- We observed staff seeking people's consent and giving them choice, however the practices in the home did not always consistently promote choice and an individualised approach to care.

The provider had failed to seek people's consent and had failed to follow the code of practice. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
- The provider had a system for inducting staff at the beginning of their employment, however we found this had not been effectively implemented and they could not demonstrate whether staff had successfully

completed induction into their role as some of the staff were not on the training records.
● The provider had not adequately established and operated a robust system for ensuring staff were provided with training. Staff had not been provided with training in key areas in line with people's needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● The provider had failed to assess people's needs and choices in line with standards and guidance. We observed staff giving people choices. However, the registered manager and their staff had not consistently followed current legislation, standards and best practice guidance to achieve effective outcomes. This included national COVID-19 guidance on allowing visitors into the care home.
● We saw evidence staff had worked with healthcare professionals to ensure people's healthcare needs were met. They worked with local GPs and nurses to meet people's health needs. However, improvements were required to ensure people were referred to other specialist professionals in a timely manner when their needs and risks had increased.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not consistently supported to maintain a balanced diet. While some people had been referred to specialist professionals to monitor risks associated with nutrition, risks with eating and drinking were not always monitored and reviewed regularly.
● We observed lunch time for one person who required staff observation whilst eating and drinking. We found that staff left this person alone with their meals and only returned periodically to prompt them with their meal. This person did not eat their meal and it went cold. They were provided with an alternative choice which was cereal.

Adapting service, design, decoration to meet people's needs
● We walked around the home to check it was a suitable environment for people to live. We saw the decoration of the home was required updating in some areas and there were marks on the walls and woodwork.
● There were adequate spaces for people to spend their time on their own or to share with others. People were able to bring their own items into their rooms and to personalise their rooms as they wanted to.

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 inadequate. At this inspection this key question has remained 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At the last inspection we found the lack of effective systems to ensure the quality and safety of the service placed people at risk of avoidable harm. The above matters demonstrate a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance).

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The service was not well-led, there were significant shortfalls in the oversight and leadership. Systems to assess, monitor and improve the service had not been implemented and operated effectively. We found no systematic approach to audits and many of the checks we were told were completed were not evidenced. Arrangements in place had not effectively identified and dealt with some of the emerging and ongoing risks to prevent deterioration.
- We found some inconsistencies in documentation. These included out of date and incomplete information. During the inspection the issues we found had not been recognised by the registered manager or provider. The registered manager and provider needed to improve their understanding of quality performance, risk and regulatory requirements.
- We found the registered manager and provider had not followed required standards, guidance and their own policies in various areas.
- The provider had systems for promoting person-centred care however, they had not been consistently applied to support the process.
- The provider had submitted some statutory notifications to CQC; however, we found a number of incidents of injuries that had not been notified and safeguarding concerns had not been shared with the local authority.

The above matters demonstrate a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance).

Continuous learning and improving care

● The provider had failed to implement systems for learning from incidents and near misses. The registered manager and the staff could not demonstrate whether they had reviewed what could be learnt from significant events such as repeated falls.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others; 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

● People were not routinely involved in the development or management of the service. Staff and the management team were not promoting or championing people's rights in this way.

● The service worked with external health and social care professionals. We saw evidence of people being supported to take part in meetings with professionals including their doctors.