Dignity Care UK Limited

Meadows Court Care Home

Inspection report

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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
Meadows Court Care Home is a residential care home providing personal and nursing care to 16 people aged 65 and over at the time of the inspection. The service can support up to 22 people. Meadows Court Care Home are registered to provide care to people in their own homes, living in the community. However, the service was not providing this type of care at the time of the inspection.

People's experience of using this service and what we found
Quality monitoring systems were in place; however, they had failed to identify some of the shortfalls found at inspection. In addition, analysis and follow up of incidents had only just been developed, more time was required to ensure this was effective.

Staff knew how to manage risks identified in relation to people's care and support. However, care plans did not always reflect peoples current care needs.

Medicines were administered safely and in their preferred way. Safe recruitment processes were in place. Staff received training relevant to their role with competency checked regularly.

Staff demonstrated knowledge of how to keep people safe from abuse and described how they would raise a concern with the registered manager or other external agencies.

There were enough staff to support people and meet their needs. Systems were in place for people, staff and relatives to share their views about the service provided.

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 15 April 2021)

Why we inspected
The inspection was prompted in part by notification of a specific incident. Following which a person using the service died. This incident is subject to a coronial investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of environmental safety and admission to the service. This inspection examined those risks.

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 have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

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

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

We have identified breaches in relation to the assessment and management of potential risks to people's safety, infection control management and organisational governance 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.

Meadows Court Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the 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
The inspection was carried out by one inspector

Service and service type
Meadows Court Care Home is a 'care home'. People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement dependent on their registration with us. Meadows Court Care Home is a care home without 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 information gathered as part of monitoring activity that took place on 22 February 2022 to help plan the inspection and inform our judgements. We used all this information to plan our inspection.

During the inspection
We spoke with two people who lived at Meadows Court Care Home about their experience of the care provided. We also observed the care and support people received as some people were not able to share their experiences with us. We spoke with four members of care staff, housekeeper, a senior carer and the registered manager. We looked at a range of records. This included four people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

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 requires improvement. The rating for this key question has remained 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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risk were not always assessed effectively.
- People who required support with catheter care did not have care plans or guidance in place. This meant staff lacked information of how to support people with catheter care, if there were a blockage for example there was not any information of the medical intervention required. This placed people at the risk of delayed treatment.
- The provider failed to assess and mitigate risks when people were admitted to the service. For example, a person recently admitted had a known risk identified of leaving their home on their admission assessment. Despite this then being recorded in a care plan there were no measures documented to mitigate this risk.
- Furthermore, care plans did not always reflect people's current needs. For example, a person could no longer mobilise and was supported in bed. This was not updated on the care plan and still referred to supporting this person to walk and mobilise. Whilst we found reviews had taken place and it had been noted 'Now cared for in bed' we could not be assured a robust assessment had been completed to meet the persons current mobility needs.
- This meant people were at risk of being support incorrectly and not in line with their current needs. The manager needed to ensure care plans reflected people's current care needs. Following the inspection action was taken to ensure care plans were updated.
- We found staff not always wearing Personal Protective Equipment (PPE) correctly, we witnessed masks were often worn below the nose. This was addressed with the manager and action was taken to address this, however, we continued to find staff wearing their mask below the nose.
- We found environmental risk were not assessed. For example, windows were not adequately restricted. Health and Safety Executive (HSE) guidance states windows should be tamper-proof. However, this was not the case and windows could be opened by hand. This meant people were at risk of harm and injury.
- Following the last inspection, it was recommended the provider developed a tool to analyse incidents. At this inspection we found this had only been in place for one month, meaning timely action was not taken to ensure systems were developed. However, we found no impact to people's safety from this delay.

The provider failed to ensure people's needs had been fully assessed. Infection control and environmental safety measures were not always effective. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● 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 was making sure infection outbreaks can be effectively prevented or managed.
● 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.

● We found measures in place to facilitate visiting. This included temperature taken on entry to the care home, alongside lateral flow testing and donning of PPE in an allocated room prior to seeing their relative.

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.

On both days of the inspection the registered manager failed to request evidence of the inspectors COVID vaccination status before entering the care home. This contravenes Government guidelines for professionals entering a care home. This was addressed with the registered manager, who stated this was an oversight and ensured all staff were made aware this must be checked before any professional enters the care home. Advice was given regarding what constitutes an emergency worker and when this would not need to be shown.

Systems and processes to safeguard people from the risk of abuse
● The registered manager had systems in place to safeguard people. Records showed staff completed training on safeguarding.
● We found a safeguarding policy in place. Safeguarding issues were identified and reported in line with the providers legal responsibility.

Staffing and recruitment
● Records showed there were safe recruitment processes in place to ensure people were supported by suitable staff. A number of background checks had been completed. These included checks with the Disclosure and Barring Service to show that the staff concerned did not have criminal convictions.
● We found enough staff to meet people's needs. People told us there was enough staff and they responded when they required assistance. One person told us, "The staff are very kind, I press the buzzer and they come."

Using medicines safely
● People received their medicines as prescribed and in their preferred way. Medicines were stored safely in a locked room with access for trained staff only.
● Staff were appropriately trained to administer medicines safely to people. On-going competency assessments were carried out by the provider to ensure staff followed safe practices.
● The provider had a medicines policy in place, which offered information and guidance for staff on best practices.
● There were protocols in place for medicines that were taken on an 'as required' basis. Staff kept accurate

records and ensured medicines were disposed of correctly.

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. 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; 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 and provider had developed systems and processes since the last inspection to monitor the safety and quality of the service. Whilst some of these were effective, we found environmental and health and safety processes had not been effective in identifying risks to people.
- For example, the building risk assessment was insufficient, with only rooms/areas of the home listed, no risks had been identified. This was acted upon by the registered manager however, the updated document still failed to identify all environmental risks and measures to mitigate these risks.
- Furthermore, audit systems in place made no reference to window safety. Meaning the provider failed to perform safety checks and identify issues. This placed people at risk of harm due to insufficient equipment in place.
- We found some of the providers policies were not sufficient. For example, the providers admission policy failed to describe on admission what information was needed about a person and when to pursue additional information. This meant people were at risk of their needs not being met due to a failure to gain adequate information.
- The provider had CCTV in place at the home, whilst there were signs around the home telling people it was in use. We found no documented evidence the use of CCTV was discussed with people or their representatives if they lacked capacity. When we spoke to the registered manager about informing people, she told us, "We just tell them [people] it [CCTV] is here."

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

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

- Systems were in place for people staff and relatives to feedback on the care provided. Feedback was gained in the form of surveys, of which the registered manager told us is supporting the improvements within the care home.
- We saw the surveys were then analysed and action put in place if any concerns were raised for example,

one person did not know how they could express their views. The registered manager had held a discussion with the person to inform them of their rights to fully express their views.
● We found evidence of resident meetings taking place, where people had the opportunity to raise any concerns they had. One resident had said, "This is one of the best care homes."

Working in partnership with others; Continuous learning and improving care
● The service had recently developed a system to analyse themes and trends following incidents. There was no evidence to demonstrate the effectiveness of the quality system, this required more time to embed.
● The service continued to work with a care consultant, the registered manager told us they found them and the provider to be supportive with the improvements at the care home.
● The service worked with healthcare professionals to ensure people had access to medical support. We spoke to a healthcare professional who told us, "The staff are always friendly, and we are informed quickly when a person requires our support. The staff always ask questions when we visit if they are not sure about a person's health."

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure people's needs had been fully assessed and measures in place to mitigate the risks identified. Infection control and environmental safety measures were not always effective, meaning people were at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure there were effective quality monitoring systems and processes in place to monitor quality and safety of the service and maintain oversight.