Meridian Healthcare Limited

# John Joseph Powell Memorial Care Centre

## Inspection report

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Tel: 01514310247

Date of inspection visit:
20 September 2021
27 September 2021
30 September 2021

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23 March 2022

## 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
John Joseph Powell is a care home providing accommodation, personal and nursing care for up to 45 people; some of whom lived with dementia and physical disabilities. At the time of our inspection 26 people were living at the service.

People's experience of using this service and what we found
Risk was assessed, and plans put in place to guide staff on how to safely manage areas of risk. However, risk management plans were not followed placing people at risk of harm. A risk assessment for one person did not have measures in place to make sure the risk was as low as reasonably possible.

People waited long periods of time before receiving the care they needed. Care monitoring records had not been fully completed to reflect the care people needed and received and they had not been reviewed daily as required.

There were insufficient staff deployed across the service to meet people's needs and keep them safe. Staff told us there had been continuous staff shortages which impacted on their ability to provide people with the safe care and support they needed.

We were not assured that safe infection prevention and control (IPC) measures were being followed. Personal protective equipment (PPE) was not used and disposed of safely, and equipment in use to support people was unclean and unhygienic increasing the risk of the spread of infection. Some other IPC practices undermined people's dignity and increased the risk of the spread of infection.

We have made a recommendation about the management of medicines. Medicines were generally managed safely, however improvements were needed to ensure the safe recording and storage of some people's prescribed medicines.

Improvements had not been made following our last inspection in April 2021. This was despite us receiving an action plan from the provider setting out how and when the improvements would be made.

There was no registered manager in post and there were inconsistencies in the management and leadership of the service.

The systems in place for monitoring the quality and safety of the service were not used effectively. They failed to identify and mitigate risk and bring about improvements to the service people received. Daily checks of the environment, aspects of people's care and staffing had not taken place as required.

People did not receive person-centred care with good outcomes. People were left waiting for long periods of time before receiving the care and support they needed. People's personal mail had not been given to them

(or their representative) for a period of up to three months and there was a risk that people may have missed essential appointments.

Records used to monitor, and review people's care were not fully completed and kept up to date. We found many examples where sections of care records were incomplete and where people's care plans had not been updated to reflect changes in their needs.

There was good partnership working with other healthcare professionals.

The Care Quality Commission (CQC) took action to address the serious concerns found on the first day of inspection. The provider was invited to complete and send an urgent action plan, setting out how they were addressing the concerns identified during the first day of our inspection, and how they intend to address other serious concerns identified by inspectors immediately. We received a detailed action plan from the provider within the agreed timescale.

On the third day of inspection we found significant improvements had been made to staffing, leadership, care records, the delivery of care, IPC practices and the cleanliness of equipment, however it should not have required a CQC inspection to prompt the action.

Rating at last inspection
The last rating for this service was requires improvement (published 16 June 2021) and there were breaches of regulations. At this inspection we found continuous breaches of regulations and further breaches of regulations.

You can read the report from our last inspection, by selecting the 'all reports' link for John Joseph Powell Memorial Centre' on our website at www.cqc.org.uk.

Why we inspected
CQC received information of concern about people's safety, staffing and the management of the service. As a result, 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. For more details, please see the full report which is on the CQC 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.

We have identified breaches in relation to risk management, staffing, preventing and controlling infection

and the governance and leadership of the service.

Please see the action we have told the provider to take at the end of this report.
Where we are taking or proposing to take enforcement action but cannot yet publish the actions due to representation and appeals process the text below must be added under this heading.
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 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.

# John Joseph Powell Memorial Care Centre

**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.

Inspection team
The first day of the inspection was carried out by an inspector and an inspection manager. The second day of inspection was carried out by a medicines inspector and the third day was carried out by two inspectors.

Service and service type
John Joseph Powell Memorial Centre 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 the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection visits were all unannounced.
Inspection activity started on 20 September 2021 and ended on 07 October 2021. We visited the service on 20, 27 and 30 September 2021.

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 six people who used the service and two family members about their experience of the care provided. Throughout the course of the inspection we spoke with care, nursing and ancillary staff, acting managers, area director and other senior managers within the organisation.

We reviewed a range of records. This included 10 people's care records and 10 people's medication records. We looked at recruitment records for one staff member employed since the last inspection.

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

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

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. 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 regulations 12.

- Risks to people's health and safety were not monitored and managed in a safe way.
- Monitoring records in use for recording the care delivered showed people had not received the care and support they needed in line with their risk management plans.
- People at risk of skin breakdown were not always repositioned at the required intervals and people at risk of dehydration did not receive the support they needed to maintain sufficient amounts of fluid to keep them hydrated.
- Monitoring records were incomplete and had not been reviewed each day as required. For example, the target amount of fluid people needed to consume each day to minimise the risk of dehydration was not recorded. In addition, the total amount of fluid people had consumed over a 24-hour period had not been calculated.
- One person required their drinks to be thickened to reduce the risk of choking, however there was a jug of un-thickened juice on the person's bedside table. Staff explained the person could not independently access drinks, however there was a risk that staff less familiar with the person's needs may offer them the un-thickened juice.
- A risk assessment for one person's behaviour did not assure us that adequate measures were in place to meet the persons needs and keep other people safe from the risk of harm. Staff also expressed concerns that they did not feel adequate measures were in place in respect of the person to meet their needs and minimise the risk of harm to other people.
- Environmental hazards placed people at risk of harm. Rooms to store mobility equipment and a trolley containing hazardous cleaning products were left open and accessible to people posing a risk to their safety. The door to a storeroom containing flammable items and which displayed a sign 'Fire door keep shut' was held open by a stack of boxes.

This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment)

of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took immediate action to mitigate the above risks to people.

Preventing and controlling infection
● We were not assured that people were fully protected against the risk of the spread of infection including those related to COVID-19.
● Staff were observed wearing face masks under their chin and nose and not changing disposable gloves in between use. A staff member was observed serving breakfast to one person in their bedroom and making their bed wearing the same pair of disposable gloves, they left the persons bedroom wearing those gloves.
● There were identifiable clinical waste bins located around the service for the safe disposal of PPE, however used PPE was disposed of in domestic bins in people's bedrooms.
● Equipment in use to support people was unclean and unhygienic. Bedrooms chairs, pressure relieving cushions, sensor mats and commodes were heavily stained with spillages, bodily fluids and food debris.
● One person's care plan stated they were independent with oral hygiene although staff were required to hand them their toothbrush and toothpaste. There were two toothbrushes on the person's bedside table which were encrusted with a build-up of dried and hardened matter.

Learning lessons when things go wrong
● It was difficult for us to assess how and if lessons had been learnt following accidents and incidents as the providers systems for recording and monitoring incidents and accidents were not being used effectively. Records were fragmented and incomplete.
● The systems in place did not assure us that lessons were learnt, and people were protected from the risk of further incidents occurring.

We found evidence that people were at serious risk from harm as the provider failed to robustly assess the risks relating to the health safety and welfare of people and systems were either not in place or robust enough to demonstrate safety was effectively managed. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accurate and complete records were not kept in respect of people. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider failed to ensure suitability qualified, competent and skilled staff were deployed; and that these staff received appropriate support. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although improvements were made to strengthen checks on the suitability of staff deployed, we found other concerns in relation to staffing which meant the provider was still in breach of regulation 18

● There were insufficient numbers of staff to meet people's needs and keep them safe.
● On the first day of inspection there were extreme staff shortages. Three care staff had not turned up for work and staff on duty confirmed they were struggling to meet people's needs. A housekeeping member of staff was deployed to the kitchen because there was no chef, this left one housekeeper to carry out cleaning tasks across the service. There was no laundry assistant on duty putting additional pressure on care staff as

they were managing the laundry.
● We found multiple examples where people did not receive the care and support, they needed in a timely way, staff also confirmed this. Their comments included, "There's never enough staff, it's a real struggle" and "Residents are left waiting and don't get the care when they need it because there's just not enough of us."
● People told us they waited a long time for staff to respond to their requests for assistance. Their comments included, "Not enough staff, ring bell and no one comes" and "Undermanned, not enough staff. If you need help you wait hours."

The provider failed to ensure sufficient numbers of staff 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.

● More regular checks had taken place on agency nurses deployed at the service to ensure their suitability and continuing professional development.
● The recruitment of staff was safe. A range of pre- employment checks were carried out to assess the fitness and suitability of staff.

Using medicines safely
● Medicines were generally managed safely. However, we found some areas in need of improvement.
● During the inspection one person received their time-specific medicine two hours late, staff did not record the time when this medicine was administered so we were not assured if this was regularly administered properly.
● Thickener powder required for people with swallowing difficulties to reduce the risk of choking or aspiration, was not managed properly. However, managers addressed this following the inspection.
● Some people did not have photographs to help staff identify them in their medicine's records which meant there was a risk medicines could be given to the wrong person.
● Guides to help staff administer medicines used when required were available in peoples records but lacked individualised detail. We saw some improvements were made to these guides.

We recommend the provider considers current guidance on the storage and recording of prescribed medicines and take action to update their practice.

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 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.

At our last inspection the provider failed to operate effective systems to ensure the safety and quality of the service. 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.

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

- There had been a lack of consistency in the management of the service. The previous manager left following our last inspection in April 2021.
- An interim manager was appointed however prior to them commencing work, management oversight was provided in turn by managers from local sister services. The interim manager left shortly before this inspection and management oversight was again provided in turn by managers from local services. Although managers from other services were suitably qualified and experienced, they lacked knowledge of people's needs and staff.
- The quality and safety of the service had not improved since our last inspection despite assurances given by the provider that they would make the required improvements. Breaches of regulations remained outstanding and we found other concerns in relation to people's safety, governance and leadership of the service.
- The systems and processes for monitoring the quality and safety of the service failed to identify and mitigate risk and bring about improvements. Checks on the environment, aspects of people's care and staffing were required to take place twice daily and be recorded as part of the providers quality monitoring systems. However, records of the last check dated back to 13 September 2021 and checks prior to this were inconsistent.
- There was a lack of scrutiny by the provider to ensure that the systems for assessing and monitoring the quality and safety of the service were fully implemented.
- Records used to monitor, and review people's care were not fully complete and kept up to date.

This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 did not plan, promote or ensure people received person centred and high-quality care.

● People did not always receive person centred care with good outcomes. People did not receive the care and support when they needed it and some practices undermined people's dignity and placed them at risk of harm.

● People or their representatives had not received personal mail. There was a box full of unopened mail in the office addressed to people using the service. Date stamps and other information on the envelopes indicated mail was up to three months old and contained hospital letters, pension letters and greeting cards. There was a risk that people had missed essential appointments and contact from family and friends.

● Although care plans were reviewed each month there was no evidence that people or their representatives were involved. We found examples where care plans had not been updated during reviews to reflect changes in people's needs.

● Family members told us they were kept informed about their relatives and they described staff as kind and caring.

We found evidence that people were at serious risk from harm as, systems were either not in place or robust enough to demonstrate effective systems for checking on the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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; Working in partnership with others

● The provider understood and acted on the duty of candour. They shared the findings of our inspection with relevant others.

● Staff had engaged with healthcare professionals when changes were made to meet people's 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<br><br>The provider had failed to robustly assess the risks relating to the health safety and welfare of people. |

**The enforcement action we took:**

Serve NOP to cancel the registration of the location John Joseph Powell Memorial Centre.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The providers systems were either not in place or robust enough to demonstrate effective systems for checking on the quality and safety of the service and the provider failed to maintain accurate and up to date records in respect of service users. |

**The enforcement action we took:**

Serve NOP to cancel the registration of the location John Joseph Powell Memorial Centre.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider failed to ensure sufficient numbers of staff to meet people's needs and keep them safe. |

**The enforcement action we took:**

Serve NOP to cancel the registration of the location John Joseph Powell Memorial Centre.