Agincare (Derby) Limited

Queensferry Court Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Queensferry Court Care Home is a care home providing personal and nursing care to up to 56 people. The service provides support to people with a physical disability, sensory impairment, mental health needs and older people, including those with dementia. At the time of our inspection there were 39 people using the service. Within the home there are 3 wings, split over 2 floors with communal lounges and dining areas. People have access to a secure outdoor area.

People's experience of using this service and what we found
People were not always protected from the risk of harm. Records were not always accurate or complete which meant staff did not always have guidance to support people safely. The home was not cleaned to a high standard, well maintained or free from environmental risks. Not all staff knew how to raise a safeguarding, or where to find this information. Lessons were not always learned when things went wrong and staff did not always recognise when accidents, incidents or near misses should be reported. Medicines were not managed safely, and people did not always receive their medicines as prescribed.

Lack of oversight and poor governance systems meant some risks, or areas for improvement, were not always identified and acted on quickly. Staff did not receive clear guidance or direction to understand their roles and responsibilities which impacted on people's outcomes.

Staff were not suitably trained to carry out their roles. People were placed at risk of malnutrition and dehydration. Staff worked alongside relevant healthcare professionals; however improvements were required to ensure staff were clear on recommendations to follow to help improve people's health outcomes. Not all areas within the home were dementia friendly, or accessible.

People's holistic needs were assessed prior to moving into the home, which included nationally recognised evidence based tools. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People, relatives and staff had some opportunities to feedback into the running of the service. The provider was working alongside partner agencies to improve safety to people using the service.

Staff were recruited safely, and there was enough staff deployed at the service.

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

Rating at last inspection
The last rating for this service was good (published 30 April 2021).

Why we inspected
We received concerns in relation to the management of pressure care, food and fluid monitoring and oversight at the service. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

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

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, staffing, nutrition and hydration and governance at this inspection.

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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work with the 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 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Queensferry 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 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 2 inspectors, a pharmacist inspector and a specialist nurse advisor.

Service and service type
Queensferry Court Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Queensferry Court Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection the manager had applied for registration with CQC. They have since moved on

from this position and withdrawn their application.

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 (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 11 people who used the service and 7 relatives of people who used the service. We spoke with 10 members of staff including the manager, operations manager, deputy manager, nurses, care assistants and kitchen staff. We completed observations of communal areas. We reviewed a range of records including 10 people's care records, food and fluid charts, medication administration records and some records relating to the management of the service were also reviewed.

Inadequate

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 good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- People were not always protected from risk. Information regarding people's risks was not always up to date, accurate or consistent between records. For example, 1 person's diabetes care plan had not been updated to reflect that care home staff were now responsible for their insulin administration. There was a lack of guidance within this care plan as to what was normal for that person, and when to escalate concerns. One person's blood sugar levels were noted to be high, but we could not verify whether this was normal for them or if this had been raised with the GP. This placed them at risk of unsafe diabetes management.
- Risks associated with people's healthcare needs were poorly managed. People were not supported to maintain good skin integrity. There was no guidance in place for staff to ensure people's pressure relieving equipment was set correctly. As some people at the service had pressure sores, this increased the risk of people's pressure care needs not being managed appropriately.
- Healthcare professionals had advised 1 person required hourly re-positioning to support with pressure relief. However, records showed significant gaps between re-positioning, of up to 24 hours. At the time of our inspection, this person had skin integrity concerns, and told us they were regularly uncomfortable.
- People who were identified as at risk of falls were not supported to mitigate this risk. One person told us they had recently fallen from their bed and they were worried about falling again. No action had been taken to mitigate this risk as the person was cared for on a standard height bed, with no crash mat or equipment to prevent falls from their bed. This placed them at risk of harm.
- People were not supported in a safe environment. During our inspection we found cleaning solutions, prescribed thickener for drinks and dangerous items such as disposable razors, within the drawers in the kitchenettes in communal areas. These were accessible to people using the service. One person had been assessed as at risk of ingesting items that were unsafe. This placed people at risk of harm.

Using medicines safely

- Medicines were not managed safely. Processes were not in place for the timely ordering and supply of medicines as medicine administration records (MAR) showed some people had not received their medicine as it was out of stock. MARs were not always able to demonstrate people received their medicines as prescribed. This placed people at risk of their health deteriorating.
- Supporting information to aid staff in administering medicines that had been prescribed on a when required basis were not always in place. Therefore, information to inform the staff on how and when to administer these medicines safely was not always available. This placed people at risk of not receiving their as and when required medicines appropriately.
- Checks of the controlled medicines failed to identify that an pain relief solution, which had a short expiry date when opened was out of date by 18 months. This placed people at risk of being administered out of date and ineffective medicines.

● Some people using the service required pain relief via a skin-based patch. Records showed the patches were not being rotated around different skin sites to comply with the manufacturer's guidance. Rotating the site is important to ensure the medicine is being absorbed into the bloodstream effectively. This placed people at risk of harm.
● Where medicines were being administered covertly, the provider failed to ensure they were prepared and administered in accordance with professional guidance. Covert medicines are administered by disguising them in either food or drink. The pharmacist had been consulted with for 1 person's covert medicine protocol and advised this medicine could be given in water. Nurses had been administering this medicine within the person's porridge. This placed them at risk of harm as some medicines can become ineffective when mixed with certain foods or drink.
● Refrigerator temperatures were not being correctly measured. The service was therefore not able to show that medicines requiring cold storage conditions were being stored within the correct temperature range to ensure the medicines remained safe and effective, placing people at risk of harm.

Preventing and controlling infection
● The home was not cleaned to a high standard. Some areas, furniture and equipment within the home were visibly dirty and carpets throughout the building were in a state of disrepair and unclean.
● Whilst the provider's infection prevention and control policy was up to date, staff and managers did not always adhere to the policy. For example, in relation to training and supervision requirements to support IPC practice or frequent cleaning of surfaces.

People were not protected from risks and people were not supported in a clean and safe environment. Medicines were not managed safely. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded to the concerns listed above immediately and secured unsafe items within the home. Care plan summaries had been updated for all people using the service. An action plan was in place to review and update all care plans and risk assessments to ensure they covered all identified risks to people. Clinical support was provided to oversee medicines within the home, including increased checks. The person at risk of falls was purchased a lower bed. Although some concerns had been identified by the provider, we are not fully assured at this time that risks to people will be consistently and effectively assessed and mitigated. This is because timely and effective action had not been taken to address them.

● We were somewhat assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.

Visiting in care homes
The service was supporting people to receive visits in line with current government guidance.

Learning lessons when things go wrong; Systems and processes to safeguard people from the risk of abuse
● Lessons were not always learnt when things went wrong. External agencies had shared areas for improvement with the provider, such as the monitoring of food and fluid, however during our inspection sufficient improvements had not been made.
● Staff did not always recognise concerns, incidents or near misses. This meant they were not always reported and acted on to prevent re-occurrence. For example, during our inspection, we found 1 person's pressure relieving mattress to have been beeping all night as the pressure had fallen. No staff had taken

action to resolve this until it was raised by inspectors.
● The provider was working with the local authority to review and investigate all accidents, incidents and safeguarding concerns at the service. Some immediate action had been taken following this to help mitigate risk but further improvements were required to ensure lessons were consistently learned.
● Staff confirmed they had received training about how to protect people from abuse and understood the signs to look for and who to report to internally. However, they were unable to tell us who they would report to externally. Staff knew there was a safeguarding policy but were not sure how to access it.
● People told us they felt safe at the service, and had someone they could raise concerns with in the event they didn't feel safe. One person told us, "I feel safe here yes, I would say if I didn't."

Staffing and recruitment
● There were enough staff employed to support people. During our inspection, staff were quick to meet people's requests for support and communal areas were supervised.
● The provider followed safe recruitment practices. Pre-employment checks had been made before staff worked with people.
● People and their relatives confirmed there was enough staff available to support them. This included staffing for peoples commissioned 1 to 1 support. One relative said, "[Staffing] seems to be a lot better now, there's lots more staff on. I used to worry in case the 1 to 1 didn't watch [relative], but they do."

Inadequate

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Staff were not always appropriately trained to carry out their roles. Not all staff had completed their mandatory training. For example, 1 member of staff had not received up to date manual handling training and we observed them support a person following a fall. This placed the person and staff member at risk of harm.
- Feedback from staff did not demonstrate they had received sufficient support to make sure their competence was maintained to support people living at the service and their known risks. For example, we asked some staff on the signs they would look out for that might show a person is dehydrated, they responded they did not know as they'd not received any training in this area.
- Staff told us they did receive an induction when they started with the service. However, staff had not received regular supervisions or ongoing support to review their practice. Competency checks had not been carried out to ensure staff were working in line with training and best practice. This placed people at risk of receiving unsafe and ineffective care.
- Not all relative's felt staff were suitably trained. One relative told us during a visit the fire alarm sounded, when they asked a member of staff what to do, the staff member said they did not know as they had not had any training. The providers training matrix confirmed not all staff had completed the relevant training which included fire safety. This placed people at risk in the event of a fire.

The provider failed to ensure staff were competent to provide safe and effective care. This placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had identified training as an ongoing action to be addressed. Following our inspection, the provider told us that staff had been reminded again to complete all their mandatory training.

Supporting people to eat and drink enough to maintain a balanced diet

- People were at risk of malnutrition and dehydration. Food and fluid records were not consistently in place for those identified at risk of malnutrition, or dehydration. This meant accurate monitoring could not be completed to enable staff to make referrals to the appropriate health care professionals when needed.
- People were not fully supported to eat and drink enough. Where food and fluid charts were in place, these did not show people had been offered enough to eat or drink. For example, 1 person had a target of 1200ml to drink each day, records showed they had only been offered and drank 200ml on several occasions within the last 2 weeks.

● We observed people asking for drinks throughout the day. Staff did not always respond to requests promptly. This meant people were left thirsty. Relatives also shared concerns people did not get enough to drink, 1 relative told us their loved one needed prompting to drink however did not feel staff always remembered to do this. This placed them at risk of dehydration.

The provider failed to ensure peoples nutrition and hydration needs were consistently met. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's diets and preferences were catered for. The cook had information of people's dietary needs. This included cultural and health needs regarding diet.
● People had a relaxed dining experience. People told us they enjoyed the food. Staff were available to provide support during mealtimes.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Systems in place did not always support staff to provide consistent, effective and timely care. An electronic system was in place to monitor people's health and well-being, but not all staff were confident in using the system. This meant records were not always completed, or flagged for handover, so senior staff or managers could promptly follow up on any concerns.
● Staff worked with a range of visiting healthcare professionals. Further improvements were required to ensure any recommendations were clearly recorded so staff had the relevant information to help support people's health and wellbeing.
● We received mixed feedback from people and relatives regarding access to healthcare provision. One relative told us, "I'm happy with how staff manage [relative's] diagnosis." One relative told us, "[Relative] had a chest infection, nothing was done until I insisted they get a doctor." Another told us their relative had missed a healthcare appointment and this had not been followed up by staff.

Adapting service, design, decoration to meet people's needs
● Improvements were required to ensure the environment was dementia friendly. There was a lack of signage around the service to help people navigate their way around their home. As there were 3 wings with a similar layout and rooms had the same numbers, this increased the risk of disorientation for people living with dementia.
● Some facilities were not designed in an accessible way. For example, a shower tray was on a high raised platform. Both the tray material and the raised platform posed a slip and trip risk.
● The provider was refurbishing areas within the home to improve the environment.
● People's bedrooms were personalised with photos and items important to them.

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Staff understood the principles of the MCA. Staff were able to show us where they would find information regarding capacity assessments, best interests decisions and any conditions on legal authorisations. These were generally in place where appropriate, for example for decisions around medicines, or receiving care.
● The provider had applied for DoLS where required.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Some nationally recognised tools were used to monitor people's health and wellbeing. This included the Malnutrition Universal Screening Tool to assess people's nutritional needs and the Waterlow score to assess people's pressure sore risk. Further improvement was required to ensure these tools were used to consistently inform people's care and support.
● A holistic assessment of people's needs was completed prior to them moving into the service. Relatives told us they were involved in this process.

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The providers systems to monitor risk within the service were not effective. Audits were not accurate therefore did not identify risk. For example, medicine audits, skin integrity audits and IPC audits did not accurately reflect what we found during our inspection. The provider did not review these audits so had not identified this or taken action to address any inaccuracies.
- Oversight of skin integrity concerns was not effective. There was no analysis of why there was an increase in the number of residents developing pressure damage and reasons for any significant deterioration, such as lack of re-positioning. This placed people at ongoing risk of harm.
- Accidents and incidents were poorly managed. There was no effective system or process in place to review, investigate, monitor or take action when incidents occurred which affected the health and safety of people who used the service. For example, an accident and incident audit for January had not been completed until the last week of March. This meant any action to mitigate risk was not identified quickly. This audit was not completed fully, or accurately. This placed people at risk of harm.
- Audits had not been used to improve safety or drive improvement. For example, a staff file audit had identified staff had required up to date training and supervisions. This action had not been completed, which meant people were at risk of receiving unsafe care from untrained staff.
- The provider had not taken effective action to ensure staff were clear about their roles and responsibilities, particularly in relation to record keeping and escalating concerns. Gaps in recording and concerns regarding people's skin care and fluid intake meant people were at risk of pressures sores and dehydration.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The service was not consistently well-led. There was a lack of direction to help staff understand the key risks and priorities for the service which impacted on the culture within the home. This meant people were not always supported to achieve good outcomes.
- We received feedback that managers were not always available. Not everyone knew who the manager was. One relative told us, "We don't see any managers, they never answer the phone, all the time can't get through – we want to speak to them to iron out these issues."

The provider failed to ensure effective systems and processes were in place and implemented to monitor the service and provide safe and effective care to all people living in the home. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People spoke positively about specific care staff that supported them. We observed kind, respectful interactions and genuine relationships between staff and people. One relative told us, "The staff I can only describe as angels without wings." A person told us, "Everybody is very friendly."

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

● People, and relatives had some opportunities to feedback into the running of the service. Due to COVID-19, relatives association meetings had been paused, but there were plans to introduce these again. Following our inspection, the provider arranged meetings with relatives to discuss any concerns they had.

● Staff said they felt supported by the manager and told us they would raise any concerns or issues regarding their day-to-day work with the manager or a senior staff member. There were opportunities for staff to give their views, such as through team meetings.

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 manager understood the importance of duty of candour within their role. Relatives told us they were informed when their loved ones were involved in accidents and incidents by staff, however improvements were required with communication from management.

● The management team were working closely with health and social care professionals to improve safety to people using the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not always protected from the risk of malnutrition or dehydration.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People were not always protected from the risk of harm. The home was not clean, well-maintained or free from environmental risk. People did not always receive their medicines as prescribed. This placed people at risk of harm.

The enforcement action we took:

Warning notice