Meridian Healthcare Limited

John Joseph Powell Memorial Care Centre

Inspection report

McKenna's Court
11a High Street
Prescot
Merseyside
L34 3LD

Tel: 01514310247

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12 September 2016

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01 November 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We visited the service on 12 September 2016. This inspection was unannounced.

John Joseph Powell Memorial Centre is registered to provide nursing care for forty-five people. The service is located in the Prescott area of Liverpool, close to local shops and road links. There were 37 people using the service at the time of this inspection.

A registered manager was not in post at the time of this inspection visit. However a manager had been appointed and they had applied to become the registered manager with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We carried out an unannounced comprehensive inspection of this service on 10 March 2016 and found that the service was meeting all the requirements of Health and Social Care Act 2008 and associated Regulations. After that inspection we received concerns in relation to the management of people's medication, unsafe care and the leadership of the service. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for John Joseph Powell Memorial Centre on our website at www.cqc.org.uk"

At this inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Prior to our inspection we received concerns from commissioners about the management of people's medication. We found improvements had been made in response to those concerns, however we found other concerns. This included people not receiving their prescribed medication because they were not available and a lack guidance in relation to the use of some people's medication.

Prior to our inspection we received concerns from commissioners about the premises. We found some improvements had been made in relation to the concerns raised. However the lack of security at the entrance of the service remained a concern; because the main door was wide open on our arrival. In addition to this fire exits were obstructed with equipment causing a risk to people in the event of a fire or having to evacuate the building in the event of an emergency.

Prior to our inspection we received concerns from members of the public and commissioners about the care and welfare of people. We found some improvements had been made in relation to the concerns raised, however we found ongoing concerns. The monitoring of some people's care was ineffective. This was

because monitoring records such as fluid and repositioning charts did not include essential information to ensure people received effective care. For example, the amount of fluid people needed to consume in a 24 hour period to remain hydrated was not recorded on their fluid intake chart. In addition the amounts of fluid people had consumed were not calculated to determine whether or not they had achieved their required target. The settings of air flow mattresses were not always recorded on repositioning charts as required, which meant there was no guarantee that mattresses were correctly set to people's individual requirements.

Prior to our inspection we received concerns from members of the public and commissioners about the leadership of the service. We found some improvements had been made in relation to the concerns raised, however we found ongoing concerns. Quality monitoring systems failed to identify the lack of effective and safe care planning for people who used the service. New care planning documentation which had recently been completed did not accurately reflect people's care need requirements, putting them at risk of unsafe and ineffective care.

Since the last inspection in March 2016 the management of the service had been inconsistent which caused unrest amongst people who used the service, family members and staff. However a permanent manager had recently been appointed and had applied to the Care Quality Commission to become the registered manager. Positive comments were made about the new manager including, "She [manager] is supportive and approachable", "The new manager has made some good improvements already" and "I've noticed a positive difference already".

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 safe.

People did not always receive medication prescribed by their doctor.

Entry to the premises was not secured.

Obstructions to fire exits posed a risk to people in the event of a fire.

Is the service effective?

Requires Improvement

The service was not effective.

Monitoring records did not include essential information about people's needs.

Care records did not provide consistent information about people's needs.

Is the service well-led?

Requires Improvement

The service was not well-led.

There was no registered manager in post at the time of the inspection visit.

Some quality monitoring systems failed to identify risks to people's care.

John Joseph Powell Memorial Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of the service on 12 September 2016. This inspection was done in response to concerns which we received about the service. The inspection was undertaken by one adult social care inspector and a pharmacist specialist inspector.
During this inspection we spoke with seven people who used the service. We spoke with three family members, the manager, a senior operations manager, and six other staff who held various roles including, nurses, care staff, domestic staff, and the chef and maintenance person.

We looked at care plans and supplementary records for four people, and medication administration records (MARs) belonging to nine people who used the service. Other records relating to the management of the service which we looked at included quality monitoring records.

Prior to this inspection we received information of concern from members of the public and commissioners of the service which we used to help plan our inspection.

Requires Improvement

Is the service safe?

Our findings

Before our inspection we received concerns from commissioners about the management of people's medication and the safety of the environment. We looked at those concerns as part of this inspection. Whilst we found improvements had been made in relation to the concerns raised about the management of people's medicines and the environment, we found ongoing concerns.

People told us that they felt safe living at the service and that they got their medicines when they needed them. A family member confirmed that their relative had not received food supplements which had been prescribed by a GP, they did however tell us that their relative had received all other medication at the right times.

Medicines were not always given as directed by the doctor, which meant that people were put at risk. For example, one person who was prescribed an inhaler for their asthma was not given it on one day as the inhaler could not be found. A second person was not given their food supplement for four days, as the supplement drinks had been stored in the person's wardrobe and could not be located by staff. A third person who was prescribed a medication patch for a health condition they had did not have a body map to show where the patch had been previously applied. A body map guides nursing staff not to use the same place that had been used before as this may increase the risk of side effects.

This was a breach of Regulation 12(2)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people using the service were not protected from the proper and safe management of medicines.

Controlled Drugs (CDs) (prescription only medicines that are controlled under the Misuse of Drugs legislation) were being stored securely. Medicines fridge temperatures were recorded in accordance with national guidance.

Medicines Administration Records (MARs) had photographs and allergies recorded for eight of the nine people's records we looked at, which reduces the risk of a medicine being given to the wrong person or to a person with an allergy. We observed a medicines round and noted that this was carried out in a professional and caring way.

The premises were not always safe and secure putting people's safety at risk. On our arrival to the service we found that the front door was wide open. This was despite previous concerns about the security of the front entrance which had been raised by other visiting professionals. The door was secured after we raised this with the manager. Two fire exits on the ground floor were obstructed, one with weighing scales and another with a hoist. The obstructions were cleared after we raised this with staff.

We recommend that more frequent checks on the environment are carried out to ensure people's safety.

Requires Improvement

Is the service effective?

Our findings

Before our inspection we received concerns about the care and welfare of people, including the lack of care planning and monitoring of people's care needs. We looked at those concerns as part of this inspection. Whilst we found improvements had been made in relation to the concerns raised, we found ongoing concerns.

Systems in place for monitoring aspects of people's care were not effective because they did not reflect important information about people's needs. Some people who were at risk of dehydration required their fluid intake monitoring. Charts to record people's fluid intake were in place; however they were not completed fully. Charts included a section for recording fluid target. The section should have been completed to show the amount of fluid people needed to consume in a 24 hour period in order for them to remain hydrated. However, this was not recorded on any of the fluid intake charts which we looked at. The charts also included sections for recording fluid consistency required, the total amount of fluid consumed by the person each day and a section to show whether or not the person had achieved their targeted fluid intake. None of these sections had been completed. In addition none of the fluid charts had been signed at the end of the 24 hour monitoring period, as required. This meant that there was no accurate monitoring of people's fluid intake, putting them at risk of not receiving the right care to meet their needs.

Some care records provided inconsistent information about people's needs. For example, a diet notification sheet for one person which was completed in July 2016 indicated that the person required thick pureed meals and stage one thick and easy syrup. However a pen picture held in the person's care file stated that they required soft mashable diet. The person's care plan for eating and drinking stated that they required normal fluids and a soft diet. The use of thickener and consistency of fluids to be given was not recorded on the person's fluid intake chart as required. A diet notification sheet for another person showed that they required normal food textures, however a nutritional risk assessment completed on 26 June 2016 and a pen picture completed for the person stated they required a soft diet. This meant people were at risk of not receiving the right care to meet their needs.

Some people had an air flow mattress on their bed to minimise the risk of developing pressure ulcers. In addition, charts were in place where required for monitoring people's positional changes to relieve their pressure areas. The front page of the charts included a section which required details of the pressure setting of the mattress. However for some people this section had not been completed. In addition the mattress setting section on the actual daily positional change record had also not been completed as required during each positional change. This meant that there were no records to show that mattress settings had been maintained at the correct level, putting people at risk of not receiving the right care and support.

This is a breach of Regulation 17 (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as accurate and complete records in relation to people's care were not maintained.
This is a breach of Regulation 12 (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as reasonable practicable steps were not taken to mitigate risks to people because their care plans were not followed.

Requires Improvement

Is the service well-led?

Our findings

Before our inspection we received concerns about the leadership of the service, including inconsistencies in the leadership and ineffective monitoring of people's care. We looked at those concerns as part of this inspection. We found improvements had been made in relation to the concerns raised, however we found ongoing concerns.

People who used the service, family members and staff said that there had been a lot of changes to the management of the service since the last inspection which they had found difficult. Their comments included, "It's been quite difficult at times as you never know who the manager is going to be", "It's caused a lot of unrest and uncertainty" and "We are told to do things differently by different people".

At the time of this inspection there was no registered manager in post at the service. Since our last inspection in March 2016 the previous registered manager had been absent from work for a number of months prior to resigning from their post in July 2016. During the absence of the registered manager there had been a number of changes made to the day to day management of the service. This included the transfer of registered managers from other services operated by the registered provider to provide short term management cover. In addition there had also been a number of changes made to the senior management team who were responsible for overseeing the service.

A new permanent manager who was recently appointed was in post at the time of this inspection and they had applied to the Care Quality Commission to become the registered manager of the service.

The systems in place for monitoring the quality of the service and making improvements were not always effective. The manager and other senior staff were responsible for carrying out checks at various intervals on things such as the environment, care plans, medication and staff training and performance. However, some of the checks had failed to identify improvements needed in relation to; the environment, the management of medication and care records. Additional checks carried out by other senior managers who visited the service regularly on behalf of the registered provider had also failed to identify some of the concerns. This meant people were at risk of not receiving safe and effective care.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as insufficient and ineffective systems were in place to assess, monitor and improve the service that people received and to protect them from the risk of harm.

We were told that the registered provider had introduced new care planning documentation to the service. We were also told that it was an improvement on the previous documentation used because it better captures all the information required for assessing, planning and reviewing peoples care. At the time of this inspection the new documentation had been completed for 14 people. However the concerns we found in relation to the monitoring and recording of people's care were in relation to people whose care had been planned using the new documentation. We recommend that the service seek support and training, for the relevant staff about the completion of care planning documentation and supplementary records.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People using the service were not protected from the proper and safe management of medicines. Reasonable practicable steps were not taken to mitigate risks to people because their care plans were not followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Insufficient and ineffective systems were in place to assess, monitor and improve the service that people received and to protect them from the risk of harm. Records in relation to people's care were not accurate or complete.