Meridian Healthcare Limited

John Joseph Powell Memorial Care Centre

Inspection report

McKenna's Court
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Prescot
Merseyside
L34 3LD

Tel: 01514310247

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20 April 2021
07 May 2021

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15 June 2021

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
John Joseph Powell is a care home providing accommodation, personal and nursing care for up to 45 people in one adapted building over two floors with lift access to the upper floor. 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 assessments relating to the health and safety of people were completed, however records did not always reflect the care people needed and the care provided to safely manage identified risks. Monitoring records in use for people who were at risk of dehydration and skin breakdown did not always provide all the necessary information and guidance for staff to effectively manage risk. These records were not always completed to demonstrate that people had received the care and support they needed.

A number of permanent nurses were recruited recently however there was still a reliance on the use of agency nurses to cover some shifts. Although an initial check was carried out on agency nurses at the point of deployment further checks did not take place to ensure their continuing professional development.

There were systems in place for monitoring the quality and safety of the service, however they were not always used effectively. Audits and checks failed to identify and mitigate risk associated with people's care, staffing and the environment. There was a lack of oversight by the manager and provider to ensure that the systems for assessing and monitoring the quality and safety of the service were fully implemented.

Medicines were safely managed, and safe processes were followed for the recruitment of staff. Staff knew what constituted abuse and they were knowledgeable and confident about reporting any concerns they may have about people's safety. People told us they felt safe living at the service and that they trusted staff. Family members were confident that their relative was kept safe and well cared for.

The environment was clean and hygienic, and staff followed good infection prevention and control (IPC) practices. People and their family members spoke positively about their experiences of the care provided by staff and they described the manager as approachable and supportive. Staff commented on how morale amongst the staff team had improved since the appointment of the new manager in January 2021.

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

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 28 March 2019). There were no breaches of regulation found, however we made recommendations about staffing and records. During this inspection we identified breaches of regulations.

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

Joseph Powell Memorial Centre our website at www.cqc.org.uk.

Why we inspected
The inspection was prompted in part by information of concern CQC received about the management of people's care and treatment. This inspection examined those risks.

Due to the COVID-19 pandemic, we undertook a focused inspection to only review the key questions of safe and well-led. Our report is only based on the findings in those areas reviewed at this inspection. The ratings from the previous comprehensive inspection for the Effective, Caring and Responsive key questions were not looked at on this occasion. Ratings from the previous comprehensive inspection for those key questions were used in calculating the overall rating at this inspection.

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

The provider took some action during and following the inspection to mitigate the risks.

The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

We have identified breaches in relation to Regulation 12 (Safe care and treatment) Regulation 17 (Good governance), Regulation 18 (Staffing) at this inspection.

Please see the action we have told the provider to take at the end of this report.

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 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.

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 inspection visit was carried out by two inspectors and a dementia care specialist nurse advisor (SpA).

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 manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided. A new manager was appointed in January 2021 and they have started the process of applying to CQC to become the registered manager.

Notice of inspection
We announced the inspection visit from the car park prior to us entering the service. This was because we needed to obtain information about COVID-19.

Inspection activity started on 20 April 2021 and ended on 07 May 2021. We visited the service on 20 April 2021.

What we did before the inspection

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We reviewed the information we received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We also sought feedback from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with nine people who used the service about their experiences of the care provided. We also spoke with the manager, five members of staff including care workers, ancillary staff and an area director. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at the recruitment files for three staff employed since the last inspection.

After the inspection visit
Due to the impact of the COVID-19 pandemic we limited the time we spent on site, and were unable to speak with family members, due to visiting restrictions. Therefore, we requested records and documentation to be sent to us and reviewed these following the inspection visit. We contacted five family members by telephone about their experiences of the care provided.

We continued to seek clarification from the provider to validate evidence found.

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 the last inspection this key question was rated as requires improvements. At this inspection this key question has remained the same. 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;

- Risk was assessed however it was not always monitored, recorded and managed in line with risk management plans.
- Some people's fluid intake records showed large gaps between fluid being offered or taken and the total amount of fluid people had consumed each day had not always been calculated and recorded. There was a lack of records for two people to show aspects of their care had been monitored in line with guidance provided by other healthcare professionals.
- Food and fluid intake charts and positional change charts in use to monitor and manage risk were not always fully completed. Sections about people's needs had not been completed including dietary needs, allergies, fluid intake target and airflow mattress settings. Daily checks on air flow mattress settings were not completed and we found some mattresses were incorrectly set.
- One person's choking risk assessment had not been updated to reflect the change in risk from medium to high. A referral to the falls team had not been made for another person who experienced a significant increase in falls.
- Parts of the environment posed a risk to people's safety. The door to a storeroom full of equipment such as wheelchairs, walking frames and hoists was wide open presenting a trip, slip and falls hazard. The manager advised it should be kept locked. Hazardous items which posed a risk to people's safety were left in communal areas; including hairspray, curling tongs, hair dryer, hairbrushes and shower gels. The door to the storeroom was secured and the items were removed after we raised it with staff.

The provider failed to adequately assess and mitigate risks. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- There were enough staff on duty to meet people's needs and keep them safe. However robust checks were not always carried out to ensure the suitability of some staff deployed.
- The use of agency nurses had reduced recently following the recruitment of permanent nursing staff. Although an initial check was carried out on agency nurses at the point of deployment further checks did not take place to ensure their continuing professional development.
- Care staff and nursing assistants were knowledgeable about people's needs and they responded in a timely way to people's requests for support. The agency nurse on shift at the time of our visit told us they were unsure about people's needs and relied heavily on the knowledge of carers. They commented that the shift was generally run by senior carers. The agency nurse received a handover on commencing their shift and a record of it was made. The handover records lacked detail and did not include details of a wound

dressing the agency nurse was required to replace that day.

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

● Safe recruitment processes were followed. Applicants fitness and suitability to work at the service was assessed through a range of pre-employment checks prior to a job offer being made.

Preventing and controlling infection
● Measures were in place to prevent and control the spread of any infection. Staff had access to current IPC guidance, and we were assured the guidance was being followed.
● Staff and people using the service had access to regular testing and COVID-19 vaccinations. Safe visits were facilitated in line with government guidance on care home visits.
● The environment was clean and hygienic. Cleaning of high touch areas had been increased to help prevent the spread of COVID-19.
● Staff had access to a good stock of appropriate personal protective equipment (PPE), and they used and disposed of it safely.

Systems and processes to safeguard people from the risk of abuse
● There were systems and processes to safeguard people from the risk of abuse. Staff had completed safeguarding training and understood their responsibilities for safeguarding people from the risk of abuse.
● Allegations of abuse were referred to the local authority safeguarding team and a record of them was kept.

● Staff were observed treating people well. People told us they felt safe living at the service and that they trusted the staff. Family members told us they were confident their relative was safe and well cared for.

Using medicines safely
● Medicines were stored, recorded and administered safely. This included the management of 'as required' medications (PRN), controlled drugs (CDs), food supplements and thickening agents.
● Staff with responsibilities for managing medication had completed the required training and underwent regular checks to ensure their competence to safely carry out the task.
● Daily checks were carried out and recorded on the temperature of the medication room and fridges to ensure medicines were stored safely.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question remained the same. 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.

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

- Lessons were not always learnt, and improvements made. The provider failed to act upon a recommendation given at the last inspection for ensuring the maintenance of records about people's needs and the care given. We found examples were care plans and monitoring records had not been completed and updated to reflect people's needs and the care given.
- The provider had a comprehensive system for checking on the quality and safety of the service, however it was not always used effectively in identifying and mitigating risk. For example, care plan audits failed to identify a lack of care planning and monitoring of people's needs. Daily checks failed to identify and mitigate hazards associated with the environment. Also, regular assessments were not undertaken to ensure the suitability of agency nurses.
- There was a lack of scrutiny by the manager and provider to ensure that the systems for assessing and monitoring the quality and safety of the service were fully implemented. The manager had delegated tasks to other senior staff but had not maintained oversight to ensure the tasks had been completed.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on duty of candour responsibility;

- Good outcomes for people were not always achieved; because they were not effectively recorded and monitored.
- Whilst we observed staff providing people with person-centred care, records did not always show the effective planning and delivery of person-centred care. Some people's care records lacked evidence to show they had received the care they needed to fully meet their needs.

We found no evidence that people had been harmed however, 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.

- The manager submitted notifications to CQC as required in a timely way and last inspection rating was displayed at the service and on the providers website.

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

● Care plans had been reviewed regularly, however there was a lack of evidence to show the involvement of relevant others such as family members and other external professionals. Changes made to care plans were not discussed and agreed with the person, when this was appropriate or relevant others.
● Family members told us the manager and staff had kept in regular contact with them throughout the lockdown period to inform them on the wellbeing of their relative and with updates about changes to the service. However, they told us they had not been invited to take part in a review of their relative's care plan.

● Staff felt supported by the manager and they described him as supportive and approachable. They told us they attended regular group and one to one meetings and felt involved and included in the running of the service. Staff told us they had noticed a significant improvement in the morale amongst the staff team since the manager was appointed.

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 adequately assess and mitigate risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems to ensure the safety and quality of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure suitability qualified, competent and skilled staff were deployed; and that these staff received appropriate support.