Norse Care (Services) Limited

Mayflower Court

Inspection report

93 The Meadows
Ladysmock Way
Norwich
Norfolk
NR5 9BF

Tel: 01603594060
Website: www.norsecare.co.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Mayflower Court is a residential care home providing accommodation and personal care to a maximum of 80 people. This includes support for older people who may be living with dementia or have physical disabilities. At the time of the inspection the service was supporting 55 people.

Mayflower Court accommodates people across four separate units described as 'houses' in one large purpose-built building with a central courtyard garden.

People's experience of using this service and what we found
Medicines were not being managed safely, which could impact on people receiving their medicines as prescribed. We found shortfalls in infection prevention and control (IPC) practice, which had deteriorated since our most recent IPC inspection carried out in January 2021. Poor standards or cleanliness and lack of adherence to COVID-19 government guidance placed people at risk of harm through infections. Although some people's relatives had no concerns about the quality and safety of the care provided, others disclosed numerous safeguarding concerns. We were not assured there was sufficient oversight of fire safety and other potential risks. We raised our concerns with the local authority safeguarding team.

It was not demonstrated there was adequate, robust oversight of the service, and management responsibilities were unclear. Practice observed within Mayflower Court did not show a person-centred approach at senior level, as concerns relating to people's privacy, dignity and well-being had not been identified or effectively resolved. For example, records and observations showed people did not always have access to good oral care. Lessons had not always been learned from adverse events or previous inspections by CQC or other professionals.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

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 16 July 2018). A targeted infection prevention and control (IPC) inspection was carried out by the CQC (published 14 April 2021) following an outbreak of COVID-19 at the service, where the service was inspected but not rated.

Why we inspected
We received concerns from the local authority in relation to the management of falls at Mayflower Court. As a result, we undertook a focused inspection to review the key questions of safe and well-led. We inspected and found there was a concern with person-centred care, so we widened the scope of the inspection to also

include the key question of responsive.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. 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 good to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe, responsive 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.

During the inspection we asked the provider to confirm any action taken or mitigation of risk in relation to urgent concerns we had about fire safety and medicines management. A response was provided with further information as requested.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to person centred care, safe care and treatment and good governance at this inspection.

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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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 responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Mayflower Court

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.

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 two inspectors and one Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Mayflower Court 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. Inspection activity took place between 1 June 2021 and 11 June 2021, with some aspects of the inspection carried out remotely to reduce risk during the COVID-19 pandemic.

What we did before the inspection
We reviewed information we had received 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. 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 used all of this information to plan our inspection.

During the inspection
We spoke with nine relatives about their experience of the care provided. We spoke with 15 members of staff including domestic and administrative staff, care workers, senior care workers and team leaders, a deputy manager, regional managers, the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We observed people's care and support. We reviewed a range of records. This included five people's care plan records and multiple medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including audits, policies and procedures were reviewed.

After the inspection
We raised safeguarding alerts with the local authority.

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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

● People did not always receive their medicines safely, and systems and oversight measures for medicines were not effective. This placed people at the risk of harm.

● At our inspection in 2018, we found the medicine room and medicine fridge temperatures were not always being recorded. This is necessary to monitor the safe storage of certain medicines which need to be refrigerated, such as eyedrops, insulins and antibiotic liquids. At this inspection, gaps in temperature records were still seen with 10 missing entries in the previous month's records. This meant staff would not be able to identify and escalate any concerns promptly.

● The most recent medicines audit at the service identified areas for improvement, but action taken was ineffective as we observed the same concerns. This included a confidential Medicines Administration Record (MAR) folder left open whilst on an unattended medicine trolley, gaps in fridge temperature records and poor cleanliness of the medicines room floor.

● We found two people's prescribed eyedrops had expired, but this had not been identified by staff prior to our inspection and records showed the eyedrops were still in use. We asked the provider to take action to ensure these medicines were disposed of and given safely going forward. The Deputy Manager responded promptly to our request and confirmed this had been completed.

● Where people did not take their medicines as prescribed, this was not always escalated and communicated effectively. We found one person had missed six doses of medicine for dementia in one month as they had either refused it or been asleep at the time staff were due to support them with this. Staff responsible for administering this medicine could not confirm to inspectors whether any action had been taken to review the time the medicine was offered or seek medical advice. After the inspection, the provider confirmed a referral had been made to healthcare professionals.

● There was no consistent system for recording returned medicines and there were gaps and errors in medicine stock counts. One person's relative told us, "[Mayflower Court] had run out of paracetamol and [person] had struggled from Friday into Saturday in pain."

● An empty medicine packet had been disposed of in the general waste without properly redacting the person's name. This breached confidentiality and was contrary to the provider's own risk assessment for returning medicines.

Preventing and controlling infection

● Personal Protective Equipment (PPE) was not stored safely or correctly, with loose aprons and exposed gloves stored in communal bathrooms, on top of lockers and near soiled laundry baskets. We found loose aprons in cluttered bathroom drawers with other items such as partly used toilet rolls, posing the risk of cross-infection.

● There were no provisions for staff to change or dispose of used PPE safely in key areas of the service such

as the staff room or laundry. We found the foot operated mechanisms of some clinical waste bins were broken and observed a staff member lifting the lid of one bin with their fingers to dispose of waste.
● We saw one member of staff smoking a cigarette outside of Mayflower Court with their PPE face mask worn under their chin. The mask had not been removed and safely disposed of following government guidance.
● Staff were not always bare below the elbow to ensure they could adhere to good hand hygiene. We observed staff wearing watches despite signing a form to say they had been removed on entry. This included members of the management team. Whilst we were told they were not providing personal care this did not model best practice.
● Some relatives we spoke with described a poor standard of cleanliness when visiting people. One relative told us, "One day my feet stuck to the floor. The hygiene was terrible." Another relative described finding soiled items of clothing and shoes which did not belong to their loved one.
● Staff were not seen to follow the safety measures put in place at Mayflower Court to support social distancing. We saw four members of staff using a staff room designated for only one person a time. Despite raising this with the registered manager, we found two staff members in the same staff room later in the day.

● The layout and hygiene practices of the premises did not promote safety. Whilst some areas of the service were clean and fresh, we found cleaning had not always been carried out in a thorough way. We found some shower chairs were unclean and some shower drains contained hair and debris in people's en-suite bathrooms. Large piles of folded towels and flannels were being stored in people's bathrooms where they could be contaminated with droplets from the shower or toilet.
● The laundry room was dusty and sinks were unclean with limescale on them. Washing machines were covered in dust and drips of detergent and had heavy rust to them making them difficult to clean. The member of staff in the laundry told us they cleaned the tumble driers but did not clean the washing machines as standard practice. There was no clear confirmation provided on how washing machines had been cleaned following the COVID-19 outbreak.
● Whilst the provider's infection prevention and control policy had been updated, there were no effective methods for monitoring implementation or conducting effective spot checks to ensure quality control as the service had not acted on these IPC concerns prior to our inspection.
● We were assured that the provider was continuing to admit people safely to the service. We saw the registered manager kindly redirect a person who was self-isolating in their room when they came to the doorway.
● Staff were carrying out appropriate screening on visitors for COVID-19 signs and symptoms when they entered the service and were courteous and friendly to relatives. One staff member told us, "We have noticed a massive morale boost since visits have been back in, it's been so good to have people back in the building."
● The provider was accessing COVID-19 testing for people using the service and staff and supporting them to get their vaccinations.

Systems and processes to safeguard people from the risk of abuse
● Whilst the service had received compliments from some people's relatives, we received mixed feedback from others about whether they felt their loved ones received safe, good quality care at Mayflower Court. One relative told us, "Some carers are extremely nice, some have not been good."
● Staff knew what to do to report and escalate concerns about people's safety. A safeguarding policy was in place at the service, and staff received training. However, the feedback we received from relatives showed that the systems and processes were not working well as we identified areas where people were at risk, but staff had not recognised it.
● Whilst some relatives had no concerns, others disclosed serious shortfalls in the care provided. This

included the number and frequency of falls, poor reporting and communications, unsanitary environment, personal items going missing, laundry completed to a poor standard, insufficient staff numbers to support people to the toilet in a timely way and a lack of access to personal care such as regular bathing, nail care and shaving. One relative told us, "My [person] has no dignity."

● Following these comments, we raised individual safeguarding alerts with the local authority safeguarding team for investigation. We also raised an organisational safeguarding alert relating to fire safety.

Assessing risk, safety monitoring and management

● During the inspection we found fire extinguishers in some areas had a 'Warning – corrective action required' sticker on. The registered manager was unable to tell us the date when these extinguishers had been checked, the reason for corrective action being required or any risk mitigation in place.

● We also raised our concerns with the nominated individual, who explained a sprinkler system was in place at the service as well as the extinguishers in case of fire. However, as the extinguishers had been condemned, it was not clear why they remained in place as this could cause confusion to staff in the case of an emergency, especially if warning stickers were obscured by smoke. The provider told us new extinguishers were in the process of being ordered by the facilities team.

● Recommendations from the most recent independent fire risk assessment carried out on the service had not all been taken. We found items were still being stored inappropriately under stairwells, a specialist audit on fire doors had not been completed, and not all staff had received practical training in use of equipment such as evacuation chairs.

● Records relating to people's care had not been consistently completed, including fluid intake and catheter output and it was not demonstrated how gaps were being followed up to ensure action was taken. We raised this with the registered manager and regional manager during the site visit who acknowledged the records were unclear.

● Safety checks were taking places in other areas, such as gas and electrical safety and servicing of equipment such as passenger lifts. Environmental risk assessments had also been completed.

Learning lessons when things go wrong

● Analysis of themes and trends in areas such as accidents and incidents, safeguarding and complaints was not sufficiently detailed. This meant opportunities for identifying and learning from adverse events to reduce the risk of reoccurrence were not taken.

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.

Staffing and recruitment

● Staff recruitment checks were completed including referencing and Disclosure and Barring Service (DBS) checks. This was completed by the provider's HR department.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Improving care quality in response to complaints or concerns

- It was not demonstrated care was always delivered in a person-centred way, in order to meet people's preferences, choices and needs.
- Oral care was not being monitored or provided consistently placing people at risk of infections in their mouth which could impact on ability to eat, poor hygiene, lack of dignity and did not follow care plans for meeting their assessed needs and achieving positive outcomes. This had been identified prior to our inspection but the action taken had not been effective.
- We observed underwear, incontinence products, towels and flannels in communal bathrooms. These items were not identifiable as to who they belonged to, which did not respect people as individuals and did not demonstrate personalised care. Although these items appeared to be clean and unused, this also posed an infection control risk as they were not stored in people's bedrooms to reduce the risk of cross-contamination in shared spaces.
- Multiple boxes of incontinence products were also piled up on the floor in people's bedrooms. This did not respect people's privacy and dignity in relation to their continence needs and posed the risk of falling or trip hazards. Despite relatives complaining about this, action had not been taken across the service to consider a more appropriate storage solution.
- One person's bowel medication protocol showed they needed support to drink a certain amount of fluids each day to support their continence needs. However, in the weekly records reviewed they had not achieved the amount required on any one day. Oversight systems relating to this were not effective.
- We received mixed feedback from relatives about communication from the service. Some relatives were satisfied and described regular updates from the management teams, whilst others did not feel listened to. One relative told us, "I ring and ring but never get an answer." Another relative told us they had tried to raise concerns with a team leader but "[They] didn't seem bothered and had said [they] didn't have time to call."
- It was not demonstrated relatives were always involved in relevant decision-making about people's care. For example, where a 'best interests' decision had been made about giving a person their medicines covertly, there was no record of any conversation with the person's family.
- Plastic squares were placed over tabletops at mealtimes rather than a traditional tablecloth or placemat. This was not a dignified approach to ensuring the tables were kept clean whilst also ensuring a pleasant dining environment for people.
- Whilst we observed the majority of staff to be kind and caring, we saw one incident where a person asked a member of staff for help in the corridor. The staff member told the person they would come back to assist them, but did not return, and were shortly seen in another part of the service.

The provider had failed to ensure the care provided was designed in a person-centred way, engaging with

and meeting people's preferences and assessed needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Memory boxes were in place outside of people's bedrooms to help people living with dementia orientate themselves within the building. However, much of the interior decoration in hallways was bland and did not have landmarks or effective signage to support people to navigate the premises. The registered manager told us the décor was being reviewed.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● We observed staff engaging with people with choosing activities they wanted to do, including playing musical instruments and walking in the garden where there were small animals including chickens. One relative told us, "The local supermarket drop flowers off and the care home use them for flower arranging."
● One person's care records showed staff had supported them to have a glass of wine with their family member across a video conference call to feel more connected.

End of life care and support
● People were supported to receive visits from their relatives when receiving end of life care, ensuring emotional support and comfort from loved ones was available.
● Training was made available to staff on how to support people reaching the end of their life.

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 good. At this inspection this key question has now 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There was no system in place which ensured the registered manager and provider could demonstrate the quality and safety of the care provided was being sustained. As a result of this inspection we had to seek urgent assurances from the provider and refer concerns to the local authority safeguard teams. The provider and leadership team had not independently identified these matters and acted to reduce the risks potential or otherwise.
- During the inspection the leadership at the service could not demonstrate how they ensured that delegated tasks were monitored and of a good quality. As key members of staff were not present, they were unable to confirm how each area was being managed, what improvements may be needed or where they need to plan more resources to support. This included fire safety and facilities management, such as the cleaning team.
- At our last infection prevention and control (IPC) inspection of the service in January 2021 an external cleaning company had been employed, but this had since reverted to an in-house domestic team. Concerns about the significant deterioration of IPC practice and management of COVID-19 over a short period of months had not been independently identified. As a result, opportunities were missed to mitigate risks around infection control and lessons had not been embedded from the previous outbreak.
- There was no overall plan in place which ensured the systems in place were in line with the vision and values of the service. For example, the provider's website states, "We have robust infection control measures and enhanced cleaning regimes are in place in all our homes and schemes. Our staff are fully trained to ensure infection prevention and control measures are strictly followed." This was not demonstrated to be the case during the inspection process.

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

- Feedback from people's relatives and our observations on-site did not demonstrate a consistently engaging and empowering person-centred culture, and concerns about privacy, dignity and the quality and safety of care had not been identified or effectively acted upon prior to our inspection. One relative told us, "They [Mayflower Court] have fallen behind what they should be."
- The doorbell to Mayflower Court was not working and there was a number for visitors to call for access instead. This did not consider accessibility for visitors without a mobile telephone or consider relatives and people anxious to see one another after restrictions during the pandemic. One relative told us, "The outside

bell does not ring when visiting. [Another relative] was extremely frustrated as [they] had to wait sometime to get into the building. There is a phone number to ring but [they] couldn't get through."
● There was a program of refurbishment planned but there was a lack of information about what benefits this would have and how it supported the aims of the service and would improve the experience of those receiving care. The registered manager told us relatives and people had been consulted on this for their views. Although the three relatives we asked about this said it sounded very positive, they told us they had not been informed prior to our call. Following our site visit, newsletters and design plans were shared with people living at Mayflower Court by the registered manager for their views.

Continuous learning and improving care
● The registered manager told us a key lesson following a recent outbreak of COVID-19 was to provide more staff rooms so staff could socially distance during breaks, with only one person in the room at one time. This was not being adhered to in practice. This was contrary to the provider's own Statement of Purpose, which states an aim and objective is, "To have quality improvement systems geared towards continuous improvement."
● Poor recording of medicines fridge temperatures was still identified as a concern, despite being raised at our 2018 inspection and in the provider's own audits. This demonstrates a history of failing to respond adequately to safety concerns raised by CQC.
● A small fire had recently occurred in the laundry room in February 2021, requiring assistance from the fire service. Despite this, all recommendations made in the most recent independent fire risk assessment in February 2021 had not yet been completed 4 months later. We also found some fire extinguishers within the building had been condemned for 3 weeks at the time of our inspection, but no action had been taken.

The provider had failed to ensure there were effective systems in place to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite concerns about how work was delegated and overseen, staff told us they felt supported by the management team. One staff member told us, "There is an open-door policy, you can see management, they are always available." Records showed team meetings and supervisions took place providing an opportunity for staff to discuss their practice and any wider information related to Mayflower Court.
● Equality and diversity and whistle-blowing policies were in place, and available for staff to access.

Working in partnership with others; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The service had been working with the local authority team to improve their response to falls and had completed falls analysis to try and identify reasons behind this.
● People's care records showed healthcare professionals were contacted for input into their health and welfare.
● A duty of candour policy was in place at the service.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure the care provided was designed in a person-centred way, engaging with and meeting people's preferences and assessed needs.

The enforcement action we took:

Impose conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to robustly assess the risks relating to the health safety and welfare of people.

The enforcement action we took:

Impose conditions

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

The enforcement action we took:

Impose conditions