MMCG (2) Limited

Minster Grange Care Home

Inspection report

Haxby Road
York
YO31 8TA

Date of inspection visit:
15 April 2021
19 April 2021

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Minster Grange is a residential care home providing personal and nursing care to 58 people at the time of the inspection. The service is registered to support up to 83 older people. We identified only 62 beds were available at the time of inspection. We are dealing with this outside the inspection process. The service is across three floors and five units.

People's experience of using this service and what we found

People were not safeguarded from the risk of harm. The building was not adequately secure. Incidents were not always recorded appropriately, the management team had not ensured action was taken to prevent future incidents occurring and that the appropriate people were informed.

Procedures were not in place to safely support people in isolation in relation to the COVID-19 pandemic. This put people, staff, relatives and others at risk of the spread of infection.

There was insufficient staff to meet people's needs. This meant people had to wait for personal cares and meals and did not receive person centred care.

People were not fully supported with choices of meals. There were no menus in place and staff did not always know what was available for lunch to inform people.

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. Records of consent, capacity assessments and best interest decisions were not always in place when people had to move rooms and units within the building.

Systems in place had failed to improve the quality and safety of the service. The provider had failed to make sufficient improvement following our last inspection and further deterioration was identified at this inspection.

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

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 22 October 2020) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to staffing, mental capacity act, person centred care and leadership of the service. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

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.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

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 Minster Grange Care Home 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 staffing, safeguarding, risk management, person centred care and 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.

At this inspection we recognised that the provider had failed to notify the commission of safeguarding incidents and serious injuries. This was a breach of regulation. Full information about CQC's regulatory response to this 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.

Special Measures
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 of 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 always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Minster Grange 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 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
Three inspectors carried out this inspection. An Expert by Experience made telephone calls to people's relatives. 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
The service did not have a manager registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided. A new manager had recently started at the service.

Notice of inspection
This inspection was unannounced.

What we did before 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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with twelve relatives via telephone. We spoke with a variety of staff including the registered manager, deputy manager, two registered nurses, four senior care workers, three care workers, the chef and admin staff.

We reviewed a range of records. This included people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including monitoring systems.

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

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment
At our last inspection we identified the provider had failed to ensure there was sufficient staff. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● There was insufficient staff to meet people's needs on both days of inspection. For example, people required support and assistance from staff, but no staff were available.
● Staff told us they were not always able to provide people with personal cares at a reasonable time. Care records confirmed this. For example, one person's care records detailed they had not had personal cares as there was not enough staff available to support them. Other people's care records showed they were not supported with personal cares until after late afternoon.
● The providers own observations on one unit had identified significant failings with staff deployment. Personal cares were still been carried out after lunch time, and appropriate staff had not been deployed to offer shower or baths and support with hydration.
● There was not enough staff to support people at mealtimes. People had to wait long periods of time for their lunch.
● There were no activities coordinators at the time of inspection. Staff did not have enough time to provide people with stimulation.
● The provider used a dependency tool to work out staffing levels to meet people's needs; however this was based on the service as a whole and for two people we could see this was not accurate. The inconsistencies in records meant we could not be assured the dependency tool was fit for purpose.
● Rotas were not always accurate or up to date.
● On our arrival to the service on both days, the numbers of staff on shift did not match what the manager told us the staffing levels should be.
● Relatives told us, "There is a lack of staff there is never anyone free unless you go and find someone. If you ring you never see anyone, but [Name] looks clean but there is no stimulation for [Name]." And, "A lot of staff have left I know that there has been agency recently. There is no consistency of carers [Name] tells me they have lots of different ones."

Failure to have sufficient numbers of staff is a breach of regulation 18, (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection the manager advised dependency assessments would be reviewed based on

individual units and the provider was employing staff to support at lunch times.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Risks to people were not safely managed. Known risks had not been effectively managed to prevent them reoccurring.
● The building was not adequality secure. There was a shared reception area and corridor with another business . Systems in place did not mitigate the risk of unauthorised people accessing the units.
● When incidents had occurred, they were not used as learning opportunities to prevent reoccurrence, so people continued to be at risk of harm.

The was a breach of regulation 12, (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Staff were not observed to be wearing the correct PPE when people were shielding.
● Effective systems were not in place to support people when they were isolating. During the inspection we were shown into one person's room who should have been isolating. Staff were not aware and there were no notices on the door.

Risks in relation to the control of infection were not being managed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Systems in place did not always safeguard people from abuse. The management team were not always aware of incidents that had occurred. This meant appropriate action had not been taken to mitigate these and report them to external agencies as required by law.

Systems and processes were not operated effectively to prevent abuse of service users. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● People received their medication as prescribed.
● Staff received medicines training and had their competency assessed.

Requires Improvement

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices, delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet

- People were not supported with a choice of meals. At our last inspection we asked the provider to promote choices of meals for people. At this inspection we found further deterioration in the choice of meals.
- There were no menus in place and staff were not aware of what meals were available, until the dinner trolley arrived. We observed staff on two separate units unaware what the meals were and, one staff had to ring the kitchen to find out what the meals were.
- Staff told us people were offered the same tea every night consisting of sandwiches and soup. We reviewed people's monitoring charts which showed for example one person had sandwiches for their tea every day plus two days for their lunch.
- People who required modified meals didn't receive a choice of what they wished to eat. Staff supporting people with their adapted meals were unaware what food they were giving to people.
- A new menu had been developed and implemented after the inspection. There was no evidence of people been involved in the development of this new menu. People's care records did not always contain their preferences so they could be taken into account.

Failure to consider people's choices and preferences at mealtimes was abreach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Supervisions were not consistently completed. We reviewed three staff files and there was no record of supervisions. There was no up to date supervision matrix in place. The new manager informed us they had started supervisions and would ensure these were regularly completed.
- Induction procedures were in place, but for two staff, there was no records of inductions being completed.

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 Act 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Applications to deprive people of their liberty had been submitted. However, these records were not always accessible. For example, we requested to review one person's deprivation of liberty application and the registered manager was unable to access this.
● Mental capacity assessments and best interest decisions were in place for some decisions but not all. For example, when people had to move rooms due to the provider closing one of the units these had not been considered.

Adapting service, design, decoration to meet people's needs
● The provider was looking at plans for storage areas as equipment such as wheelchairs were stored in communal bathrooms.
● Rooms had signs on the doors and pictures to help people identify the rooms they required. Memory boxes were outside bedrooms and had been personalised with pictures and items of interest/meaning.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Staff supported people to access health care professionals.
● Advice from professionals had not always been followed. For example, during the inspection we saw senior staff wearing a particular coloured uniform. Advice from a health professional had been not to wear this colour uniform as it was a known trigger for some people's behaviours.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has 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; Continuous learning and improving care

At our last inspection we identified the provider failed to assess, monitor and improve the quality and safety of the services provided which was a breach of regulation 17. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had failed to make the improvements required since our last inspection. We identified numerous repeat failings as a result of this inspection.
● Systems in place were not effective. They had not always identified the issues we found and when they did identify some issues, adequate measures had not been taken to address them. This was a failure to manage risks posed to the health, welfare and safety of people. This included safe staffing levels, security of the building and risk management.
● People continued to be at risk of harm due to the poor leadership and governance of the service.
● The provider had repeatedly failed to learn lessons from feedback and incidents leaving people at risk of potential harm.
● Records were not always fully completed or accurate. For example, At the last inspection we reported records regarding people's hygiene including oral hygiene were not consistently completed. At this inspection we found no improvements had been made to people's hygiene records and these still contained gaps.

Failure to assess, monitor and improve the quality and safety of the service was a breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A new manager had started at the service prior to our inspection. A new senior management team were also in place to support the manager.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider had failed to address the issues reported at our last inspection regarding poor communication with relatives.
● Relatives were not always able to get through to the service by phone and did not feel they were kept up

to date with changes in the service. Feedback included, "I have trouble getting through on the phone weekends are worse it just rings and rings finally someone answers they put you through to the unit then no one picks up its really difficult. To try to book a visit you have to ring up they answer then say you need to speak to the office, and no one answers. When they don't answer you think there are not enough staff." And, "Things have changed there I read about the new unit in the paper. We need more information about what is happening."

● Staff were not fully engaged in the service as they did not feel listened to. Feedback included, "No one is going to listen to you, the head office has given us the impression they don't care about us. We are just numbers there is no communication from them. I cannot see the point in discussing anything now as they do not do anything."

Failure to take on board feedback to drive improvements in the quality and safety of the service was additional evidence of the breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong, Working in partnership with others

● The provider had not always submitted notifications about events such as serious injury and safeguarding incidents to CQC as they are required to do by law.

The failure to notify as required was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We are looking at this outside of the inspection process.

● The provider could not always be open and honest as incidents were not always correctly recorded, so the management team were not aware to ensure the correct people were informed in line with the duty of candour.

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

● People did not always receive person centred care due to the poor staffing levels.

● Staff were observed to be kind and caring. However, they were under increased pressure due to the failings identified in this report and therefore unable to deliver the care they wanted to.

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 9 HSCA RA Regulations 2014 Person-centred care People were not supported to have sufficient choice with their meals in line with their preferences. 9(3)(g)

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 ensure people received safe care and treatment. Incidents had not been reviewed to ensure risks to people were mitigated. The building was not adequately secure. The provider had failed to reduce the risk of spread of infection. 12(2)(a)(b)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not safeguarded from abuse. Systems in place were not effectively established to prevent abuse and ensure these were escalated where appropriate. 13 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care	The provider has failed to deploy sufficient numbers of staff. 18(1)

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality and safety of the service, They provider had failed to assess monitor and mitigate risks relating to the health and safety of others. The provider had failed to maintain accurate, complete and contemporaneous records. Systems in place did not ensure effective communication with staff and relatives. 17 2 (a)(b)(c)(e)

The enforcement action we took:

We issued a warning notice