Morris Care Limited

Isle Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

About the service
Isle Court Nursing Home is a residential care home that was providing personal and nursing care to 61 people aged 65 and over at the time of the inspection. The service can support up to 80 people across three separate units. One of the units specialises in providing care to people living with dementia.

People's experience of using this service
People were not always supported to have maximum choice and control of their lives. Staff did support them in the least restrictive way possible; the policies and systems in the service did support this practice.

We have made a recommendation people, relatives and significant others are involved in care reviews.

We have made a recommendation that the management team ensure all staff receive formal supervision in line with company policy.

We have made a recommendation that the management team gather people's experiences of care delivered on all three units of Isle Court Nursing Home.

We received mixed feedback on how people were treated with dignity and respect. People told us staff availability impacted on the care they received but staff were caring. We observed positive interactions and saw staff had a good rapport with people.

Medicines were managed safely. Infection prevention was managed to minimise risk and keep people healthy. Staff had received training on what constituted abuse and the actions to take should it be witnessed. There were robust recruitment procedures to ensure suitable staff were employed.

All staff received induction shadowing and mentoring to promote effective knowledge of their role. The registered manager worked with other agencies to promote positive health outcomes for people. People said the food was good and plentiful, with the appropriate support being offered. Isle Court Nursing Home was well maintained and free from hazards to minimise environmental risks.

Everyone at Isle Court Nursing Home had a care plan. These were under review to ensure people's long-term needs were appropriately identified. Staff had received training around people's communication needs. There was a staff member employed to co-ordinate activities for people. These included activities within the home, trips out and arranging visiting entertainers.

During the inspection process the registered manager post became vacant. The registered provider placed a senior manager on site as house manager to provide stability until a new registered manager could be recruited. The registered provider had created a new role of pastoral support co-ordinator to support people, families and staff. The registered provider advertised this role as a listening ear for everyone. Clinical

and quality audits monitored the quality and safety of the service.

Rating at last inspection: At the last inspection the service was rated good (published 07 September 2016.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement: Action we told provider to take (refer to end of full report)
We have identified breaches in relation to staff availability to meet people's needs and good governance to meet all statutory regulations at this inspection.

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 monitor the progress of the improvements working alongside the provider and local authority. We will return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

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

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 dropped to requires improvement.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service dropped to requires improvement.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service dropped to requires improvement.

Details are in our Caring findings below.

Is the service responsive?

Good

The service was good.

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service dropped to requires improvement.

Details are in our Well-Led findings below.

Isle Court Nursing 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. This inspection was planned to check 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
One Inspector, one assistant inspector and two Experts by Experience completed the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts by experience had experience of caring for older people who received support.

Service and service type
Isle Court Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 on the first day.

What we did
Before our inspection, we checked the information we held about Isle Court Nursing Home. This included notifications the registered provider sent us about incidents that affect the health, safety and welfare of people who received support.

We also contacted the commissioning and contracts departments at the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. This helped us to gain a balanced overview of what people

experienced when they received support at Isle Court Nursing Home.

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. All the information gathered before our inspection went into completing our planning document that guides the inspection. The planning document allows key lines of enquiry to be investigated focusing on any current concerns, areas of risk and good or outstanding practice.

During the inspection we walked around the building to carry out a visual check. We did this to ensure the home was clean, hygienic and a safe place for people to live. We activated the call bell twice times during our visit to assess staff availability and response times. We spent time watching day to day activities, communication, relationships and care practices taking place. We did this to assess the quality of interactions that took place between people living in the home and the staff who supported them.

We spoke with 20 people who lived at Isle Court Nursing Home, 11 relatives and two friends of people living at the home. We spoke with the registered manager, deputy manager, clinical services manager and two nurses. We also spoke with one visiting healthcare professional, six staff and the chef. We corresponded with the chief operating officer after our inspection site visit. We looked at the care records of seven people, training and recruitment records of three staff members, records related to the storage and administration of medicines and the management of the service.

We looked at what quality audit tools and data management systems the provider had. We used all the information gathered to inform our judgements about the fundamental standards of quality and safety of the service delivered by Isle Court Nursing Home.

After the inspection we received information from a relative who was unaware of our inspection visit. We continued to seek clarification from the registered manager and clinical services manager to corroborate 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.

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. Regulations may or may not have been met.

Staffing and recruitment

● We received mixed feedback on staffing levels. One person told us. "I feel safe as there is always someone around." A relative said, "I think that there is enough staff around when we are here and need them." However, concerns were raised related to staffing levels and their deployment. One person told us, "There are not enough of them [staff]. I ring and wait 20 minutes, it's been up to an hour. I get anxious if they haven't got staff." A relative commented, "I myself have helped out residents when there have been no carers on the floor and the nurse on duty has ignored ringing bells."

● During the inspection we heard one person shouting, "Please come." We observed a member of staff who was not a carer visit their room and reassure the person they would seek help. After a further five minutes we pressed their call bell. After a further 10 minutes we went and alerted staff.

● Staff told us the service required more staff to meet people's needs. One staff member commented, "Most of the time, we are struggling it's not the managements problem, I think we are experiencing a lot of staff coming and going." A second staff member said, "Unit one can fluctuate so much, it's hard to balance out with new admissions." The chief operating officer responded, stating safe staffing levels are not compromised at any time.

● The provider audit process did not include a system to ensure call bell checks were recorded and reviewed. The registered manager told us they completed weekly visual checks on a computer. There was no analysis of the call bell wait time, a member of the management team agreed this would be beneficial.

We found no evidence that people had been physically harmed, however, systems were not robust enough to review staff deployment and staffing levels safely and ensure enough staff were available to meet people's needs. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● The registered manager responded to our feedback and told us they were able to print out call bell information and would include this within their audit process. After our inspection visit, the chief operating officer told us they now monitored call response times daily and staff had received training on the call bell system and how to respond.

● The registered manager told us they used a staff dependency tool and allocated roles to staff at the beginning of their shift to ensure staff are available throughout the home. The registered manager told us they had previously increased staffing and introduced an additional member of staff to work between units one and two.

● Recruitment processes were robust and ensured staff employed were suitable to work in this type of service. Records showed that Disclosure and Barring Service (DBS) checks were completed and references obtained from previous employers before staff worked alone supporting people.

Systems and processes to safeguard people from the risk of abuse

● People were protected from the risk of abuse. Staff were trained in safeguarding procedures and could describe what was abuse and how they would report any concerns. One staff member said, "If I identified abuse I would tell the nurse in charge and speak to [registered manager] and fill out an incident report form straight away." The registered manager was aware of their responsibility to liaise with the local authority if safeguarding concerns were raised.□

● One person told us, "I have had to return again [to Isle Court Nursing Home] as I am so weak again. I returned yesterday and although I feel ill I know I am safe." One relative commented, "I have the utmost confidence in this place and when I go home I know [family member] is safe."

Assessing risk, safety monitoring and management

● Staff followed protocols to support people in an emergency. For example, people had personal emergency evacuation plans that ensured staff had the appropriate guidance in case of a fire.

● Staff understood where people required support to reduce the risk of avoidable harm. When people had ongoing health conditions, information was available to identify signs of deteriorating health and how to manage this to keep people safe.

● The environment and equipment had been assessed for safety. This was confirmed by documentation we looked at. For example, oxygen tanks were stored securely outside of the home.

Using medicines safely

● Medicines were managed safely, in line with national guidance.

● People told us they were consulted about their medicines and they received them on time. One person commented, "I get my medication on time and they make sure that I take it." A second person said, "If I am in pain, they would give me something for the pain."

● Medicines were securely stored to keep them secure and people safe.

● The registered manager supported people to maintain their independence and manage and administer their own medicines, where appropriate.

Preventing and controlling infection

● Staff followed good practice to protect people from the risk of infection. Staff told us they had access to gloves, hand gels and aprons as required. This helped prevent the spread of infections.

● The registered manager ensured infection control procedures were maintained with effective staff training. They employed housekeeping staff to maintain the cleanliness of the home. One person told us, "My room is very clean, and I can have clean sheets whenever I want."

● Isle Court Nursing Home had been awarded a five-star rating following their last inspection by the 'Food Standards Agency'. This graded the home as 'very good' in relation to meeting food safety standards about cleanliness, food preparation and associated recordkeeping.

Learning lessons when things go wrong

● The provider had processes to learn and take action to reduce the risk from incidents. Staff documented accidents and incidents. The registered manager said they reviewed them to identify trends and themes. The registered manager said they had sought advice and guidance from other health professionals when they noted an increase in the number of incidents.

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.

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

- Staff assessed people's needs before they moved into Isle Court Nursing Home to check their needs were understood and could be met. When people arrived at the home staff developed a care plan within a set time frame.
- Staff were in the process of reviewing care records and updating them at the time of the inspection. However, not all people and their relatives said they had participated in a recent review of their care. We shared this information with the clinical services manager who told us they would investigate this.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- When people were being restricted, we saw staff followed processes to ensure any restriction was lawful. Applications had been submitted to the local authority and staff were working in accordance with the restrictions.
- However, we found not all staff had suitable understanding of the MCA and DoLS.
- People and family members told us they were consulted with and were involved in developing their initial care plan. However, not everyone or their relatives were consulted when care plans were reviewed and updated.

We recommend the reviews their processes to ensure people's assessed needs are reviewed by all relevant parties and the appropriate consent is sought.

Staff support: induction, training, skills and experience

● Staff told us they had not received recent supervision. We discussed this with the registered manager and saw evidence supervisions had been occurring, but the frequency was not in line with company policy.

We recommend the provider reviews their processes to ensure all staff received adequate supervision to support them in their role.

● The chief operating officer told us after the inspection visit, a programme of supervision dates for all staff had been planned and initiated.

● Staff had the skills and knowledge to support people effectively. Regardless of their experience all staff had to complete the care certificate. This is an agreed set of national standards for health and social care staff. One staff member told us, "The induction was very good." New staff shadowed experienced staff to ensure they were competent before they could work independently.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to maintain a balanced diet. People told us they were pleased with the meals provided. One person commented, "I always enjoy the food I have a choice and I am never hungry." A second person said, "The food is alright, and I am a fussy eater. We have choices and I get enough to eat and drink." Two relatives felt the standard of food had recently improved.
● People's individual nutritional needs were met. Care plans included information about people's dietary needs and their likes and dislikes. The chef was knowledgeable about people's preferences.
● Staff monitored people's health regularly. Care plans included people's weight and meals were fortified to minimise weight loss.
● The registered provider employed stewards to deliver and serve meals and drinks. This allowed staff to spend time with people who required support.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The service worked with local health professionals to support people to move from hospital and receive treatment to promote positive health gains with the aim of returning home.
● We observed health professionals visited to complete nutritional assessments and to help people become more independent. There was a scheduled health and social care meeting for social workers and health professionals held at the home to review people's progress. One health visitor told us staff were organised and approachable.
● People told us they had access to healthcare support when they needed it. One person told us, "They would call the GP if needed, I see the chiropodist, physio, optician and we do have a hairdresser twice per week." A relative said, "The doctor is called when required and they let me know straight away if there are any changes in her or problems, which I think is very good."
● The registered provider had employed an admiral nurse to work with health and social care professionals to improve people's healthcare experience. They told us, "It is a shock and a big change to all parties (when people leave home) and for us to provide good, effective, kind care, that transition has to be handled well."

Adapting service, design, decoration to meet people's needs
● The design of the service met people's needs. Access to the building was suitable for people with reduced mobility and wheelchairs. A passenger lift was available if people needed it to access the upper floors. Corridors were free from hazards to allow people to walk independently and safely. Call bells were positioned throughout the home to allow additional support to be requested, should it be required.
● People's bedrooms had their preferred names on them to promote people's independence and in

recognition of their preferences. There was a room decorated as a tea room. There was historical decoration and items displayed along the corridors to promote reminiscence and conversation.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- We received mixed feedback on how people were treated. Feedback from the forget me not unit was positive. One person told us, "They have always been so kind, caring and patient with me before and have got me going and out of my very dark mood. They are really lovely with you and want to look after you." A second person commented, "They [staff] are all very kind, and patient. They chat to me help me with everything and I never feel awkward or strange with any of them at all. I am very relaxed."
- We received feedback from the rest of Isle Court Nursing Home that did not mirror these views. People and relatives felt staff availability impacted on the care received. For example, one person said, "The staff don't have time to sit and talk to you." A second person commented, "There seem to be lots of people about but too busy to sit and speak to you unless administering care." A third person remarked, "I just lie here; no-one comes to speak to me." A relative told us, "They [staff] do the minimum and rush off to the next resident."
- We observed family members were welcomed and supported when they wished to participate in caring for their loved ones.
- We observed staff using the person's likes and history as a prompt to engage in conversation when supporting people at lunchtime.
- Every person we met during the inspection projected a positive impression of themselves. People wore appropriate clothing that was well fitting, reflected their culture and was relevant to the individual.
- Equality and Diversity training was included within staff induction.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- One person told us they had a preference on who supported them, "I prefer a female carer, I have told them this, but this does not always happen." One staff member when asked how they support a specific person with complex needs commented, "It is documented with [X] to use female carers only but we don't always have two females available so sometimes we have to send a male in with a female."
- One relative told us their family member was bathed daily and was always, "well presented". A second relative commented, "[Family member] is showered every day and treated with respect and the staff know him and understand him as an individual which is important to us because he is an individual."
- We received mixed feedback on how people felt when receiving support with their personal care. One person commented, "I don't always feel comfortable receiving personal care; I feel rushed sometimes and I can't move quickly." A second person said, "They close the curtains and they speak to me when they are caring for me, they are caring, supportive and respectful to me."
- Staff were able to tell us about the importance of maintaining people's privacy when carrying out personal care and ensured other staff knew when bathrooms were occupied.

We recommend the service engage with people and their significant others to gather their views on their experience of the care, support and treatment on all three units of Isle Court Nursing Home.

Good

Is the service responsive?

Our findings

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

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● We saw everyone at Isle Court Nursing Home had a care plan. People's care plans did not always contain information related to their long-term health conditions. The registered manager told us they were aware the care plans needed reviewing. At the time of the inspection people's care plans were in the process of being reviewed by the clinical lead.

● People's rooms were furnished to meet their personal tastes and preferences. For example, one bedroom had several pot plants which reflected the person's enjoyment of gardening.

● People told us they had the option of participating in activities or opting out. We observed several people and a visiting relative take part in chair exercises. Trips to a local castle, farm shop and garden centre had taken place. The person in charge of co-ordinating activities told us they had arranged for a donkey to visit. The explained, "Easter will be good we have a donkey coming in and some nursery school children. It will be organised chaos but fun for everyone. I am determined to get the donkey to all areas especially those who cannot leave their rooms, so they can share in the enjoyment."

● Isle Court Nursing Home had two Spa bathrooms. These had jacuzzi baths, one had colour changing lights and a television with the ability to play music playlists, films and personal photographs.

● Care plans guided staff on how to ensure information was accessible to people, highlighting if people were visually or hearing impaired. One staff member explained, "We go off body language, one lady can't speak so she does thumbs up and thumbs down."

● We saw one person had a small white board and pen next to their bed. The registered manager explained the person was hearing impaired and the white board supported positive communication.

Improving care quality in response to complaints or concerns

● The service had a complaints procedure. The procedure was clear in explaining how a complaint should be made and reassured people these would be responded to appropriately.

● Complaints had been received and communication and meetings had taken place with resolution letters being issued.

● One person told us, "I do remember making complaints, nothing done." A second person said, "I have no complaints, If I have concerns, they are usually addressed." We were unable to speak with the registered manager about these comments as they were no longer in post at Isle Court Nursing Home. A relative commented, "I have no concerns or complaints."

End of life care and support

● The service supported people to have a dignified and pain-free death. People's end of life preferences were recorded as part of their pre-assessment process. Staff had received training from a local hospice to care for people at the end of their lives. This included verification of death training.

● Staff were booked on ReSPECT training. This is a process that creates personalised recommendations for

a person's clinical care in a future emergency when they are unable to make or express choices.

● On the first day we inspected a lounge was being used for a funeral reception or wake. A couple had lived at Isle Court Nursing Home and one spouse had passed away. Their partner did not feel able to attend the funeral. The registered manager supported the family's request to have the wake at the home. This allowed the spouse the opportunity to mourn the passing of their loved one and to celebrate their life with family and friends.

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

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

- The registered manager completed a range of quality audits to ensure they provided an efficient service. However, we noted one incident involving a person and member of staff was not documented within the audit.
- People consistently told us staff response times to call bells was poor. There was no formal analysis of call bell times to investigate the feedback received and provide an action plan of improvement.
- During this inspection carried out in April 2019 we found not all fundamental standards had been met.

The above information demonstrates a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance).

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

- We saw duty of candour was applied. For example, information was shared with key stakeholders when things had gone wrong.
- We received feedback that when concerns were raised the registered manager engaged with people and their families to address issues raised.
- The registered manager met with other home managers in the registered provider's group to discuss governance and lessons learnt.

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

- The service had clear lines of responsibility and accountability. People relatives and staff were aware of the managerial and clinical roles within the home. One person said, "I do feel that the staff know what they are doing, and what their roles are."
- The registered manager had submitted notifications as required to CQC as part of their regulatory requirements.

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

- There was mixed messages on how the provider engaged with people who used the service. Not everyone we spoke with knew who the registered manager was. Feedback on the management team was mixed. One person told us, "I know who the manager is, but she does not come around and speak to us." A second person commented, "I know that there is a new manager, but I don't know who it is."

● People told us there had been several changes in the management team at Isle Court Nursing Home that had affected service delivery. One person told us, "Staff have left, all the staff I knew have gone. I would like it to feel happy here."
● Staff told us the management team were supportive and approachable. One staff member said, "[Registered manager] is very nice." A second staff member commented, "I think she [registered manager] tries to help me get better in my job."
● At the start of the inspection there was a registered manager in post. Before the inspection had been completed the registered manager post was vacant, and the registered provider was recruiting a replacement registered manager. The clinical services manager who was familiar with people, relatives and staff had taken on the role of home manager as a temporary measure to provide stability. We saw there were resident and relative's meetings. One relative told us the registered manager was approachable.
● There were daily handover meetings and unit meetings for staff and clinical meetings for nurses. Agenda points included, new legislation, staffing levels, medicines and teamwork.

Working in partnership with others
● The registered provider worked with the local authority and community health teams to support people from hospital with the goal of returning home.
● The registered manager referred people to community experts to ensure their care was suitably reviewed to promote positive outcomes. For example, people received mental health and mobility support as required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not effective to ensure compliance with the regulations. Regulation 17 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider did not deploy staff effectively to meet the requirements of this regulation. Regulation 18 (1)