Mrs Flora Rufus Mason

Malvern House

Inspection report

139 Heysham Road
Heysham
Morecambe
Lancashire
LA3 1DE

Tel: 01524414016
Website: www.croft-malvernhealthcare.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Malvern House is a residential care home providing accommodation for persons who require nursing or personal care to up to eight people. The service provides support to older and younger adults, who may have a physical disability, learning disabilities or autistic spectrum disorder or require support with their mental health. At the start of our inspection there were three people living at the home.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

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

Right Support: The provider failed to have safe and robust systems to meet people's individual needs when their behaviours were of such an intensity, frequency or duration that their physical safety was likely to be placed in serious jeopardy.

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.

Right Care: The provider failed to consistently help people have a good quality of life that supported their physical and mental health and emotional wellbeing while promoting their dignity and human rights.

Right Culture: The provider failed to act in a timely manner to ensure everyone living at Malvern House lived in a safe clean environment that promoted their privacy. The provider failed to ensure that staff interventions when people were in crisis were safe, proportionate and measurable through accredited training and comprehensive documentation.

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

Rating at last inspection and update: The last rating for this service was requires improvement (published 24 May 2021) 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 we found the provider remained in breach of regulations.

At our last inspection we recommended that audit systems be reviewed so the concerns we found could be identified by the provider. We also recommended the provider personalise policies and procedures to reflect

the management structure of Malvern House. At this inspection we have found the same concerns and they were in breach of regulation 17.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

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 inspection was prompted in part due to concerns received about the management of risk related to the support people received while living at Malvern House. A decision was made for us to inspect and examine those risks. As a result, we carried out a focused inspection to review the key questions of safe, effective and well-led only.

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

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

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

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to people not being consistently protected from the risk of abuse. Systems did not always lessen risks for people and they were not consistently treated with dignity and respect and staff did not always act in accordance with the requirements of the Mental Health Act 2005. Staff had not received all the required training to support people safely and effectively at this inspection and governance systems failed to identify the concerns found at this inspection. We have imposed conditions on the providers registration as a result of this inspection.

Follow up
We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 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 effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Malvern House

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 Health and Social Care Act 2008.

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
Two inspectors carried out the inspection on the first day. One inspector visited on the second and third day.

Service and service type
Malvern House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Malvern House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced on the first day.

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. We used all this information to plan our inspection. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection

We spoke with three people who used the service about their experience of the care provided. We spoke with six members of staff including the provider, manager, senior care worker and carers. We walked around the building to carry out a visual check. We did this to ensure Malvern House was clean, hygienic and a safe place for people to live.

We reviewed a range of records. This included people's care records and multiple medication records. We looked at two staff files in relation to recruitment and a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at their policies and quality assurance systems

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
At our last inspection 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(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● At the last inspection not, all staff had received training on Safeguarding or on how to support people who may require staff to recognise their agitation and offer ways to calm down. At this inspection not all staff had received yearly training updates as identified as required by the provider. The people being supported, or their needs may change so updating training lessens the risk that staff are not equipped to meet people's needs.
● The provider failed to ensure all care plans and risk assessments had information to guide staff on how to manage people's health and behavioural support needs.
● Not all the fire doors were well maintained. Five fire doors did not close independently into their door frame. This meant the spread of fire or harmful smoke would not have been restricted had there been a fire. The fire panel alarm was not working correctly. When we visited, we were told the electrician was onsite to fix it. Two days later we were told the electrician had gone for a part to fix it. Eight days later the panel was not fixed however the risk had lessened as no-one was living at Malvern House.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After we visited the home, the provider has scheduled safeguarding training for all staff. The provider has informed us that work has been completed to rectify the fire door closures and the error on the fire panel has now been reset.

Systems and processes to safeguard people from the risk of abuse

● The provider failed to ensure staff had the knowledge and accredited training to ensure the use of restraint or the need to control a person was the correct response at that time and this placed people at risk of abuse and improper treatment.
● The provider failed to in a timely manner provide care and support that protected people from degrading

treatment.
● The provider failed to ensure that agency staff employed to work at Malvern House had the competence skills and experience to provide safe care and treatment.
● The provider failed to provide documented strategies to guide staff on how to effectively support people when physical intervention was deemed necessary.
● The provider failed to ensure that staff consistently and comprehensively recorded when restraint had taken place, what sort of restraint was used and how long it lasted. This prevented post incident reviews and reflections to lessen the risks and to reduce the risks of restrictive practices.
● The provider failed to operate effective safeguarding processes by allowing a staff member who was under police criminal investigation to work with people who may be vulnerable.
● At our last inspection, the provider's safeguarding policy and procedure had not been adapted and personalised to reflect the location's management structure. The policy identified the registered managers responsibilities. The location did not have and did not require a registered manager as the provider managed the service. This was a recommendation at the last inspection. The policy has not changed, the provider's responsibilities had not been identified within their policy and procedures.

People were not consistently protected from the risk of abuse or improper treatment as systems and processes to safeguard people were not effectively operated' 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.

● After we visited the home, the provider told us they had scheduled restraint training for all staff from an accredited trainer.
● Staff understood their responsibilities around safeguarding people. They were able to explain safeguarding processes should they witness any signs of abuse.

Using medicines safely
At our last inspection the provider had failed to have systems in place or that were robust enough to demonstrate medicines were effectively managed and all risks were assessed and managed. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

● Medicines were stored safely and the stock we looked at matched the stock levels recorded.
● Where people were prescribed medicines they only needed to take occasionally, guidance was in place for staff to follow. This helped to ensure those medicines were administered in a consistent way.

Staffing and recruitment

At our last inspection the provider the provider had not followed procedures to ensure fit and proper staff were employed. This placed people at risk of harm. This was a breach of regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

● The provider did not consistently follow robust recruitment procedures. Criminal record checks with the

Disclosure and Barring Service were carried out and appropriate references were sought. However, not all application forms held a full employment history and there was no evidence this had been discussed with the candidate.

We recommended the provider consider best practice guidance on the recruitment of staff.

Preventing and controlling infection

● We were to some extent assured that the provider was preventing visitors from catching and spreading infections or wearing PPE effectively. On visiting Malvern House, we were asked to show evidence of a negative LFD test and our temperature was taken to see if we had an infection.

● However, we noted contracted staff, agency staff employed by the provider and visiting health professionals were not required to wear masks all of whom at times were in close contact with people who may expel bodily fluids when distressed. Current guidance on GOV.uk website states, 'Appropriate PPE should be worn by care workers and visitors to residential care settings, subject to a risk assessment of likely hazards such as the risk of exposure to blood and body fluids.'

We recommend the provider follow best practice on the use of personal protective equipment.

● We were assured that the provider's infection prevention and control policy was up to date. However, the policy stated, 'Overall responsibility for ensuring the policy is implemented rests with the Registered Manager'. The location did not have a registered manager as the owner/ provider was managing the home and solely responsible. The policy also stated, 'Uniforms should be kept clean and changed immediately if contaminated with blood or body fluids. A clean uniform must be worn each day'. Staff at Malvern House did not wear uniforms. The infection prevention policy did not reflect current practice at Malvern House. After the inspection the provider told us they had updated their policy to reflect their current practice.

● Staff told us they tested regularly for COVID – 19. We were partially assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the communal areas of the premises.

The provider supported visits for people in accordance with infection prevention guidance.

Learning lessons when things go wrong

● The provider had made improvements in medicine management and reviewed the environment to mitigate risks for people with complex needs. However, they were still in continuous breaches of some regulations. The provider stated that after reviewing incidents and documentation around how staff managed people's behaviours they would be making additional environmental changes to lessen the risks around self-harm.

Inadequate

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Adapting service, design, decoration to meet people's needs
● The provider failed to act in a timely responsive manner to ensure people's personal space and décor met their needs. Two people for a prolonged time had to live and sleep in squalid conditions. This was contrary to Article 03 of The Human Rights Act, 'Right not to be tortured or treated in an inhuman or degrading way'.

People were consistently not treated in a dignified and respectful manner that promoted their privacy. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection visit, and after people had moved from the property the provider refurbished the two bedrooms which included new beds and furniture.

Ensuring consent to care and treatment in line with law and guidance; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The provider failed to have the relevant documentation in place to evidence they were working in people's best interest.
● Staff had not received accredited training on how to deliver restraint safely.
● The provider failed to consistently evidence that before any restrictions were held, discussions took place

as to whether the purpose could be effectively achieved in a way that was less restrictive of the person's rights and freedoms.
● Some care plans did not always accurately reflect the person or their support needs. Care plans did not reflect when decisions needed to be made in someone's best interest. The provider stated they would review all care plans.

The provider failed to ensure staff acted in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff told us they had the skills to complete their role. They said they shadowed more experienced staff when they were new to their role. However, some staff had not received all the required training to support people effectively and maintain their safely.
● When staff are learning skills from other staff who are not suitably skilled themselves, care and support is not delivered in a way that meets people's assessed needs.

The provider failed to ensure some staff had appropriate training as was necessary to enable them to carry out their role. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they felt supported by the provider and daily handover meetings guided them on their roles and responsibilities.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to go shopping and purchase their preferred meals and snacks.
● People had access to the kitchen to make their own drinks or they were able to request drinks which were provided. One person told us they enjoyed baking in the kitchen.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● There was evidence the provider had liaised with local health professionals and specialised support services.
● There was evidence the provider had provided support to ensure people were able to attend their daily educational activity and activities such as swimming.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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 recommended the provider reviewed their audit processes as they had not identified the shortfalls we had found. At this inspection medicines management had improved however some quality assurance systems remained ineffective and had failed to identify the concerns we found in care planning, risk management and consent. That meant opportunities to improve safety and learn lessons had been missed.

At our last inspection we recommended the provider customise policies and procedures to reflect Malvern House. At this inspection some policies referred to the role of the registered manager. The provider manages Malvern House and does not have or is required to have a registered manager in post. The provider failed to ensure their policies and procedures reflected this.

● The provider failed to ensure staff comprehensively recorded information in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.
● Effective processes were not established to monitor and review all the risks related to the care and support people received.

Systems were not operated effectively to assess, monitor and improve the quality and safety of the service. Accurate, complete and contemporaneous records in respect of each person were not maintained. This was a breach of Regulation 17(1) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection the provider told us the policies had been updated to reflect their role and responsibilities.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● At the time of the inspection two out of three people living at Malvern House wanted to live elsewhere due to their environment and actions of some staff.
● The provider failed to take timely action to ensure people's care and treatment addressed all their needs

including health, emotional and mental health needs.
● The provider failed to ensure staff received training in person centred care to ensure they acknowledged and reacted appropriately to people's lifestyle choices, health conditions and needs.
● The provider failed to consistently adopt one person's preferred pronouns when speaking with the police, health and social care professionals and in front of the person.

You failed to ensure the consistent care and treatment was personalised and provided in a timely manner. This was a breach of Regulation 10(1) (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff spoke positively about their roles and how they enjoyed their jobs. The manager told us, "We really care and [people] they have a good life doing activities. We are going to get there."
● Satisfaction surveys completed by two people living at Malvern House and staff indicated they were happy and did not document any concerns.

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 management team understood their responsibility around the duty of candour including sharing information with other agencies when things went wrong.
● The provider failed to notify CQC without delay of incidents that are reported to or investigated by the police. The police responded to two people who were distressed on different occasions and transported them back to their staff at Malvern House. Not all these incidents were shared with CQC.

You failed to ensure all incidents that were investigated by the police were notified to CQC. This is a potential breach of Regulation 18(1)(2)(b)(f) (Notification of other incidents) of the Care Quality Commission (registration) Regulations 2009. This will be reviewed outside of the inspection process.

● The provider told us if people living at Malvern House made allegations to other organisations they were not told while investigations took place. The provider felt this prevented them from submitting the relevant information at the time and they had to wait until after any investigations had taken place before information was shared with themselves.

Working in partnership with others
● We saw evidence the provider was working with education, health and social care agencies.

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 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure staff acted in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. 11(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not operated effectively to assess, monitor and improve the quality and safety of the service. Accurate, complete and contemporaneous records in respect of each person were not maintained. 17(1)(2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure some staff had appropriate training as was necessary to enable them to carry out their role. 18(1)(2)(a)