ADL Plc

Morton Close

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Morton Close is a residential care home providing personal care and accommodation up to a maximum of 40 people. At the time of our inspection there were 27 people using the service. The care home accommodates people in one adapted building with bedrooms on the ground and second floor. The main communal areas on the third floor.

People's experience of using this service and what we found
People were at risk of harm as the provider had not identified, assessed or mitigated risks. This included risks related to people's health and care needs as well as environmental risks. The home was not clean and infection control was not effectively managed. Medicines were not managed safely which placed people at risk of harm. There were not enough staff to meet people's needs and keep them safe. The systems and processes for learning lessons were not robust. We were not assured people would always be protected from the risk of abuse.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible.

People's dignity was not always maintained. Staff did not consistently treat people with respect, kindness and compassion. Staff were task orientated which meant people did not always receive the support and comfort they needed. Communication needed to be improved. Staff and people using the service were not always kept informed of key changes and the provider did not ensure they continuously sought people's views.

Significant and serious shortfalls were identified which impacted on the safety and quality of care people received. Systems to assess, monitor and improve the service were not effective in identifying shortfalls and securing improvements. Opportunities to learn lessons and make improvements to the service had not been taken. There was a lack of effective leadership and management by both the provider and registered manager. Staff did not work effectively with other health professionals to ensure people received joined-up care.

The provider was responsive to the inspection findings and provided assurance they would make the required improvements to improve the safety and quality of care.

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 requires improvement (published 18 April 2019). No breaches of regulations were identified. However, we recommended the provider review night staffing levels to ensure there were sufficient numbers of staff on duty to meet people's needs. At this inspection we found

improvements had not been made to address this concern and staffing levels were unsafe. The provider had breached a number of regulations.

Why we inspected
This inspection was prompted by a review of the information we held about this service. We undertook a focused inspection to review the key questions of safe, caring and well-led only.

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.

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 see what action we have asked the provider to take at the end of this full report.

After the second day of our inspection our concerns for people's health and safety were so serious, we wrote to the provider and requested a response about how they would take immediate action to ensure people were safe. The provider sent us an action plan and assured us they would take action to mitigate the urgent risks to people and ensure appropriate improvements were made to the safety and quality of care provided.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Morton Close 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 monitor the service and will take further action if needed.

We identified breaches of regulations in relation to safe care and treatment, dignity and respect, staffing 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 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.

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 caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Morton Close

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
The first day of our inspection was carried out by two inspectors, a medicines inspector and an 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. The second day of our inspection was carried out by four inspectors and a medicines inspector. Following our site visit an inspector completed phone calls to people's relatives.

Service and service type
Morton Close 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. Morton Close is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the 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 the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used information gathered as part of monitoring activity that took place on 21 July 2022 to help plan the inspection and inform our judgements. We used all this information to plan our inspection.

During the inspection
We spent time with people in the communal areas observing the care and support provided by staff. We spoke with 11 people who used the service and 4 relatives about their experience of the care provided. We gathered feedback from 7 staff members including carers, senior carers, the registered manager and operations manager. We reviewed a range of records. This included 7 people's care records and medicines records for 27 people. We looked at 2 staff recruitment files, staff rotas and other records relating to staff training. We reviewed a variety of records relating to the management of the service, including policies, procedures 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 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.

Staffing and recruitment

- People were at risk of harm as there were not enough staff to keep them safe. Staff were not able to respond promptly when people needed care, support or comfort. On multiple occasions Inspectors had to locate staff to assist people who were at risk, in need of support or visibly distressed. On one of these occasions a person had fallen and were calling out for help and on two other occasions people had been incontinent.
- Systems for assessing staffing levels were ineffective. A dependency tool was used to calculate the number of staff required. This was incorrectly completed and did not include key information such as the level of people's dependency. This meant the calculations used were inaccurate and not reflective of people's current needs.
- During our last inspection we recommended the provider review night-time staffing levels. During this inspection improvements had not been made and staffing levels were unsafe.
- Staff were not effectively deployed. People told us they often struggled to find staff when they needed them. One person told us, "There's not enough staff they are over worked; it's unfair". Another person said, "There should be more staff, but they do everything. They say they will be up in half an hour". Another person told us, "They haven't got sufficient staff". A relative told us, "When we visited there was no staff around". Another person told us their relative, "Only sees people when [they are] offered a drink".
- People's feedback, our observations of staff practices and review of records indicated the training staff received did not always ensure they could deliver safe and effective care. For example, we saw staff used unsafe moving and handling practices and did not always ensure people were cared for with dignity and respect.

The provider did not ensure there were enough suitably qualified, competent and experienced staff deployed at all times to meet people's needs. This placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following our inspection the provider sent us an action plan to detail the immediate actions they would take to address our concerns. By the second day of our inspection the provider had arranged for an additional operations manager to provide extra management support and deliver staff training. Following an inspection by the Fire Authority the provider included an extra staff member onto the night shift. They also said they would introduce a twilight shift so there would be additional staff during peak times.
- Staff recruitment was managed safely, and all required checks were completed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People were exposed to the risk of harm. There was a failure to assess, mitigate and manage risks to

peoples' health and wellbeing. This included risks associated with skin integrity, nutrition, choking, use of call bells and moving and handling. Care plans were not detailed or reflective of people's current needs. Some people did not have appropriate risk assessments in place and care plans did not contain all the information staff required to be able to provide safe care.

● Where risks had been identified, appropriate actions were not being taken to ensure people's safety. For example, two people were at high risk of developing pressure sores. Both people required support from staff to have their position changed and required specialist equipment. In both cases we saw the specialist equipment was not in place or on the correct setting. We also saw gaps in both people's repositioning charts. This meant the provider could not evidence staff had taken the required actions to mitigate the risk of pressure sores for these people.

● Weight loss was not monitored or managed effectively. Records showed people had lost weight, however, it was not clear what action was being taken to address this.

● The environment was not always safe or properly maintained. For example, we saw people using an outdoor smoking area which was unsafe. We also found multiple examples where the water temperatures exceeded a safe range which exposed people to the risk of harm from scalding. Where issues for improvement in the environment were identified these were not actioned in a timely manner. For example, one person's bathroom had been out of use for over 5 weeks.

● Fire safety was not appropriately managed. Following the first day of inspection we reported our concerns to the Fire Authority. They inspected the premises and identified significant concerns with how fire safety was managed. They asked the provider to make immediate improvements.

● The systems for learning lessons were not robust. Accidents and incidents were not consistently reported, investigated or dealt with appropriately. This meant we could not always be assured appropriate action had been taken to reduce risk. For example, one person had three unwitnessed falls in the three weeks prior to our inspection. One of the falls resulted in them requiring emergency treatment. There was no evidence of action being taken to mitigate the risk of further falls and their care plan stated they had never fallen whilst at Morton Close.

The provider failed to robustly assess and mitigate the risks relating to the health, safety and welfare of people and the premises. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines were not always given as prescribed. We observed some people were given the wrong dose of their medicines because staff administering medicines failed to follow the directions carefully. Stock levels showed other people were not given their medicines as prescribed even though staff signed the records to confirm they had been administered. One person was prescribed eye drops and the records showed the drops had been given, but the bottle was still sealed another person was prescribed an eye ointment but the tube had not been opened and had not been applied.

● The medicines records were inaccurate including the time controlled drugs were administered. The quantity of medicines in the home were not always accurate, so it was not possible to tell if the medicines had been given as prescribed or if they could be accounted for. Staff left gaps on the medicine records, so it was not possible to tell if the medicine had been administered. Staff did not always make records about the creams they applied. Staff also failed to make clear records about the application of transdermal patches which meant they may not have been rotated safely in accordance with the manufacturers' directions.

● Some medicines which must given at a specific time were not always given at those times. For example, two people were prescribed an antibiotic which must be given on an empty stomach and the records were signed to show they were given at mealtimes. Many people were prescribed regular Paracetamol, which must not be given with less than a four-hour interval between doses. However, staff failed to record the time

of each dose, so it was not possible to ensure a safe time interval was left between doses.
● Written guidance was in place when people were prescribed medicines to be given 'when required'. However, the guidance was not personalised for individual people and staff did not always follow the guidance. For example, one person was given a laxative, but staff had not made any checks to ensure it was appropriate to administer it at that time. When these medicines were administered no evaluation of the effectiveness was recorded.
● Medicines were not always stored safely. For example, the temperature records and fridge temperature on the day of inspection showed insulin had been stored outside the recommended temperatures. There was no evidence any action had been taken to ensure the insulin was not adversely affected.

We found no evidence people had been harmed on the days of the inspection visits because the harm is not always immediate, however, people were placed at risk of harm by the failure to ensure the safe and proper management of medicines. This 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
● The provider's systems and processes did not support effective prevention and control of infection. The overall cleanliness of the building was poor. There were strong malodours throughout the home. Cleaning schedules were incomplete and did not evidence regular cleaning.
● Government guidance on the prevention and control of infections was not always followed. Staff did not wear personal protective equipment correctly. Some care staff wore jewellery and had their hair down. This meant risks to vulnerable people were increased and they were at a heightened risk of infection.
● The provider's infection control audit systems were ineffective. The audit system did not consistently identify and address areas for improvement or reduce risks.

People were not protected from the risk of infection as control measures were not implemented consistently. This was a breach of regulation 12 (1) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes
● The provider had a visiting policy in place. The registered manager told us they regularly reviewed visiting arrangements to ensure these were in line with government guidance. Relatives told us they could visit but were only allowed to do so in people's bedrooms due to Covid19 restrictions. The provider's policy stated one family at a time could visit in communal areas. However, several relatives told us staff had recently prevented them from entering communal areas. It was therefore not clear that staff fully understood the procedures which were in place.

Systems and processes to safeguard people from the risk of abuse
● We were not assured the systems in place would safeguard people from abuse. We saw poor oversight of incidents and accidents and multiple examples where care plans had not been followed or appropriate actions had not been taken to respond to people's needs and reduce risks. This meant people were not always appropriately protected from harm.
● Staff did not always demonstrate they understood their responsibility to report and respond to concerns. There had been a number of incidents where people had unexplained bruising. We saw these incidents not always been appropriately followed up. We saw multiple examples where staff failed to report accidents and incidents appropriately. One person told us they had only been informed their relative had an accident when they visited and saw bruising. Another person described how an external health professional had made a safeguarding alert due to concerns about their relative.

● Most staff had received training in safeguarding. The registered manager told us plans were in place to address all gaps in staff training.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● The provider was working within the principles of the MCA. People's capacity was assessed and the registered manager made applications to the relevant legal authority to deprive people of their liberty.

Inadequate

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.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity. Respecting and promoting people's privacy, dignity and independence.

- People were not consistently treated with kindness and compassion. We saw multiple occasions where people required assistance, support or comfort and staff did not respond to meet people's needs. One relative told us, "No one seems to care". Another person described in detail the poor outcomes their relative had experience since moving into the home. They said "I have never seen a person go down-hill so fast. We will all have to live with placing [them at Morton Close] forever".
- Staff were task orientated which meant they were not responsive to people's changing needs. This was particularly apparent during mealtimes where people did not receive the support they needed. We saw multiple examples where staff did not provide people with the assistance, prompting and support they required to eat. Staff did not offer people second helpings, even where people had cleared their plates. During breakfast on the first day of inspection loud contemporary dance music was played on the radio in the dining room. We saw several people becoming agitated and one person covered their ears. Staff did not respond to this. At lunchtime calmer music which was familiar to people was played. Several people started singing and waving their hands as they recognised the music.
- People were not treated with dignity and respect. We saw people wearing dirty and inappropriate clothing, and some had not received support with personal care. Five people told us they were cold and requested additional layers of clothing or blankets. Relatives told us they regularly saw people not wearing socks or shoes when they visited. One relative also described how items of clothing often went missing or were not properly laundered. On the second day of our inspection there were no clean bed sheets in the linen cupboard. We saw this impacted on several people. One person was feeling poorly and told us they wanted to do was lie down and rest. They were visibly distressed and told us, "Nobody cares about me". Staff told us they were waiting for the linen delivery but that it often came late in the day.
- Interactions between staff and people using the service were not always respectful. For example, we saw one person was given a tablet which staff had dropped on the floor and then wiped it on a tissue. We also saw some of the language used in care records was not appropriate or respectful to the individual. Communal bathrooms were cluttered with items including underwear, toiletries, hairbrushes and bars of soap and razors which had been used. These items were all unnamed so we were concerned staff would not know which people they belonged to when providing support with personal care.

People were not treated with respect, dignity and compassion. This is a breach of regulation 10 (1) (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection the provider told us they would take immediate action to address our concerns in relation dignity and respect. Some of the actions they implemented immediately after our inspection included additional staff training and observations of staff practices and increased management oversight.

Supporting people to express their views and be involved in making decisions about their care

● Staff did not always provide people with clear explanations and comprehensive information. We saw this lack of transparency impacted on people's wellbeing. For example, on the first day of our inspection there was a delay to preparing one of the lunchtime meal options. Staff did not explain this to people which we saw caused distress and confusion for several people as they did not understand why they had to wait for their meal, while other people were served their food. We also saw 4 people were unable to have the meal choice they requested because the catering provider had not sent enough. A staff member said, "We've not got enough chicken, they have not sent enough, they do this all the time, it's not fair really."

● Some people told us they felt involved in making decisions about their care. Whereas others described how they were not formally involved but felt able to approach staff if they had any problems. One person said, "I'm not involved with running the home, they just get on with it." Most relatives told us they would like to be more involved and for staff to consult them more. One relative told us, "No meetings with the home have taken place regarding how to care for [my relative] what [they] likes and dislikes. We have been asked nothing about [them]".

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.

Continuous learning and improving care;

- Significant and serious shortfalls were identified at this inspection. There were breaches in relation to risk management, infection control, dignity and respect, medicines management and good governance. These issues had not been addressed through the provider's own governance systems.
- During our last inspection we made a recommendation the provider reviewed night-time staffing levels. We also identified improvements were required to the management of pressure care, moving and handling, the completion of repositioning records and the management of safe water temperatures. The provider had not made appropriate improvements and the risk of harm to people had increased.
- Quality audits were not effective in identifying issues and securing improvements. For example, respect and dignity audits were completed by the registered manager. However, they were limited and did not include observations of staff practices. This inspection identified dignity and respect was an area where significant improvements were required.

The provider did not ensure robust systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- There was a lack of effective leadership and management. Systems were ineffective and management oversight was poor.
- Systems for managing risks to people's health and safety were ineffective. Where people were losing weight this was not always identified and addressed. Accidents and incidents were not monitored and followed up effectively. Staff did not always report or record accidents and incidents.
- Staff were not aware of important information about the people they cared for. Care plans were not reflective of people's current needs and did not contain sufficient details to ensure staff had all the information they needed to provide safe care. There were missing assessments and gaps throughout all of the care records we reviewed. Staff were unable to locate some records we requested.

The provider did not ensure risks relating to people's health, safety and welfare were appropriately assessed, monitored and mitigated. The provider also did not ensure accurate, complete and contemporaneous records were maintained in relation to the care provided. This was a breach of regulation

17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the second day of inspection our concerns for people's health and safety were so serious, we wrote to the provider and requested an action plan. The provider gave us assurances they would take immediate action to address our concerns and strengthen their oversight of the home. They also demonstrated they were working with the local authority and other agencies to make improvements.

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

● People did not always receive person centred care that led to good outcomes. People's experience was not always positive and this was reflected in the mixed feedback we received. One person told us, "It's Okay. Yes, I'm happy here". Whereas another person told us, "There's nothing to do. Not happy here; it's not for me". Another person said, "I've not told anyone I'm not happy. It's just a feeling".

● Formal systems were in place to capture people's views on the quality of care. However, the provider did not ensure people's feedback was continuously captured. For example, many people told us the quality of food had declined since a new catering provider was being used. One person told us, "Some of the [new] foods are awful, it was better when we had a cook". Another person said, "The food could be better, it's often cold". One person told us their relative "Loved the food when [they] first went in, it has changed now and [they are] no longer as keen". This had not been identified and addressed through the provider's quality assurance systems.

● Communication systems were not always effective in ensuring staff were kept informed of key changes. For example, after the first day of our inspection the smoking area was temporarily closed whilst it was made safe. We saw the door remained open on the second day of our inspection and the area was being used by people. Staff were not aware it should not be used until the administrator came to inform them.

● Staff, people and relatives spoke positively about the registered manager and said they were approachable and supportive.

Working in partnership with others

● Staff did not work effectively with stakeholders to ensure people received joined-up care. Care records did not always reflect the actions staff should take to adhere to specialist advice. This meant appropriate actions were not always taken by staff to ensure good health outcomes for people.

● Health professionals told us staff often did not follow their advice, referrals were not timely, communication was ineffective, and staff were sometimes unprofessional. One health professional said, "I can't think of anything they do well. I don't think people are well cared for here, which makes me really sad".

● The registered manager told us they had met with the district nursing team to improve how they worked together. However, the agreements which had been made were not being consistently put into practice.

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 registered manager understood the requirements of the regulations to make notifications and to comply with duty of candour responsibilities when things had gone wrong. However, people's feedback indicated there was not always transparency when incidents occurred.

● The system for learning lessons was not reliable or robust. The provider did not have an accurate overview of what was happening in the service because incidents and accidents were not always documented, investigated or acted upon.

● The provider had displayed the rating from our last inspection in the entrance to the home so people could see this information in line with regulatory requirements.