Bupa Care Homes (CFHCare) Limited

Mornington Hall Residential and 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?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

This inspection was unannounced. At our previous inspection of this service on 11 March 2014 we found that people did not always give consent to their care and treatment and the provider had not always notified the Care Quality Commission of allegations of abuse within the service. During this inspection we found the provider had addressed these issues.

Summary of findings

The home provided accommodation with nursing and personal care for up to 120 adults. At the time of our inspection 112 people were living at the service, two of whom were in hospital. The home was divided in to four units each capable of accommodating up to 30 people. One unit specialised in residential care, one in nursing care, one in nursing and dementia care and one in residential and dementia care.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

People were at risk because the service did not have enough staff on duty to meet people's needs at all times. Assessed staffing levels were not always implemented. You can see what action we told the provider to take at the back of the full version of the report.

Staff understood their responsibility with regard to safeguarding adults and risk assessments were in place which included information about how to manage and reduce risks that people faced.

Staff received training relevant to their roles, although the manager told us that the service would benefit from more training about dementia and end of life care. Staff had regular supervision meetings where they were able to discuss issues of importance to them. People that used the service had access to health care professionals, and professionals we spoke with told us they thought the home was meeting people's health care needs. People's needs were being met in relation to nutrition and hydration and people were offered choices about their food.

People were treated in a caring manner. They told us staff treated them with dignity and respected their privacy. Staff we spoke with were knowledgeable about how to support people in a way that promoted their independence, privacy and choice. People were able to make choices about their end of life care.

People were able to give their consent to care and treatment. Where people lacked capacity to make a decision about their care then best interest decisions were made. Staff had undertaken training about the Mental Capacity Act 2005 and most of the staff we spoke with had a good understanding of it. Detailed care plans were in place which set out how to meet people's assessed needs. These were followed although we found one important element of a person's care plan that was not followed relating to their health care. People's needs were reviewed on a monthly basis and people and their relatives were involved in planning care. The service had a complaints procedure in place and complaints were dealt with appropriately.

The service had effective management and leadership systems in place. There were clear lines of accountability in all areas of the home. Senior managers visited the home each month to carry out quality checks. Various audits were also undertaken by management staff within the home. The home sought the views of people that used the service. For example, through an annual survey. Staff told us they found management to be approachable and they were able to raise any issues they had.

Summary of findings

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 did not always have enough staff on duty in line with the assessed staffing levels. This meant people were at risk of not having their needs met.

People were protected from the risk of abuse. Staff had a good understanding of how to manage any allegations of abuse and the service had appropriate systems in place for responding to abuse allegations. Risk assessments were in place which set out how to manage and reduce risks people faced.

Is the service effective?

Good

The service was effective. Staff received support and supervision to enable them to carry out their duties effectively. The service had a system for monitoring staff's training needs and we found staff had access to regular training. People that used the service had their health care needs met and had routine access to health care professionals.

Where people lacked the capacity to make decisions we found that best interest decisions had been made. However, not all staff had a good understanding of the Mental Capacity Act 2005.

People's needs were met in relation to nutrition and hydration. People were offered a choice of foods and they told us they were provided with sufficient amounts to eat and drink.

Is the service caring?

Good

The service was caring. People were treated in a caring and respectful manner. Staff were aware of how to support people in a way that promoted their privacy, choice and independence. Staff worked with people in a calm and patient manner. People were able to make choices about their end of life care and relatives were also involved in this process.

Is the service responsive?

Requires Improvement

The service was not responsive. We found that care was personalised to meet the needs of individuals. Staff had a good understanding of people's needs but we found one important element of a person's care that had not been managed in line with their care plan.

The service had systems in place for responding to any complaints people made.

People were able to make choices and give consent to care.

Summary of findings

Is the service well-led?

Good

The service was well-led. The service had a registered manager and a clear management structure. People who used the service and staff told us they found the management staff to be approachable and accessible and that they were able to raise issues with them.

The service had quality assurance and monitoring systems in place, some of which included seeking the views of people that used the service.

Mornington Hall Residential and Nursing Home

Detailed findings

Background to this inspection

The inspection team consisted of an inspector and an expert by experience, who had experience with older people with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. We also had a specialist advisor for older people and dementia.

Before the inspection we gathered and reviewed evidence from a number of sources. We looked at notifications and safeguarding alerts we had received about this provider. The provider submitted information to us about how they were meeting the five key areas addressed in this report and where they thought improvements were needed. We also contacted the local authority commissioning team, an advocacy service and the tissue viability service beforehand to gather their views on the service.

The methods that we used to gather information during the visit included speaking with people that used the service and their relatives, speaking with staff, observing the care and support provided and reviewing various records and other documents. We also asked the service to provide us with further information within 48 hours of our visit. During our inspection we spoke with 12 people that used the service and three relatives. We spoke with 15 staff. This included the registered manager, the deputy manager, the cook, nurses, senior care staff and care assistants and the area training manager.

Records that we reviewed included nine care records of people which included care plans, risk assessments, daily records and pre admission assessments. We also examined records of menus, staff training and supervision records, a number of policies and procedures including the complaints, whistleblowing and safeguarding adults' procedures, records of audits, staff, residents and relative's surveys and records of a number of meetings.

Is the service safe?

Our findings

At the previous inspection of this service in March 2014 we found the service was in breach with Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. During this inspection we checked to determine whether the required improvements had been made.

At our inspection in March 2014 we found that the service had not always notified the Care Quality Commission of allegations of abuse. When reviewing the evidence we held about this service in preparing for the inspection we found that since the previous inspection the service had notified the Care Quality Commission about allegations of abuse.

Care and nursing staff we spoke with also told us at times there were not enough staff on duty to meet people's needs. We observed on one unit breakfasts were still been served at 10:30am. Staff told us this was because they were short staffed. A nurse told us, "We should have two nurses and five carers for the morning shift but we are always short one carer on a Tuesday." A care worker told us at times the service was short staffed. They said this meant sometimes people's needs were not met in a timely manner. For example, they told us if staff were supporting people in their bedrooms there were no staff to support people in the lounge if they needed to use the toilet. A nurse told us that due to lack of staff tasks were not always completed. For example they said that people were supposed to have their weight checked weekly but that one week this had not been done due to lack of staff.

Several staff told us that when the service was running with its full complement of staff they were able to meet people's needs, but said that often shifts were left uncovered. Senior staff on the individual units said they had the authority to book replacement staff if needed but that there were not always staff available to cover shifts. We examined the staffing rotas for the two nursing units over an eleven day period leading up to the day before our inspection. These showed that on 14 different shifts the service did not have its full complement of staff according to the assessed staffing levels. This meant people were potentially at risk of not having their nursing and care needs met.This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Most people we spoke with told us they felt safe. One person said, "I feel safe, I have friends here and you can go in and out. We can sit around and talk with friends." A relative told us the person that used the service was, "Absolutely safe, nothing can happen to her, she is under supervision." Other people told us that at times they felt unsafe because there were not enough staff. One person told us, "Sometimes I feel safe and I feel unsafe when there is a lack of staff when they are very hurried in their work and trying to get everyone seen to. It is worse at weekends." A relative we spoke with said "Very helpful staff but not enough of them."

The registered manager told us the home did not use any form of physical restraint on people but that bedrails were used to reduce risks. We found that where bedrails were in place a risk assessment had been carried out and we noted that bedrails contained padding to help make them safe for use.

Staff we spoke with were knowledgeable about how to support people who exhibited challenging behaviour. For example one person had threatened to stab himself and staff we spoke with were aware of the actions they needed to take to reduce any risk to this person. However, this information was not included in the person's risk assessment. Other care plans we looked at relating to people's challenging behaviour were more comprehensive. For example, there was a detailed care plan about managing sexually inappropriate behaviour of one person. We observed that staff supported people who exhibited challenging behaviour in a sensitive and supportive manner. We saw staff interacting with people in a calm and patient way which helped them to become less agitated.

We found that risk assessments were in place about managing risks associated with people's clinical and nursing needs. For example, we saw detailed risk assessments about the care of pressure ulcers, management of diabetes and risks of falling. Staff we spoke with had a good knowledge of people's risk assessments in these areas.

Staff also had a good understanding of issues related to safeguarding adults. Staff were able to name the different types of abuse and identify signs that indicated a person might have been abused. All staff we spoke with were aware of their responsibility for reporting any allegations of abuse. The service had a policy in place for dealing with allegations of abuse which made clear their responsibility

Is the service safe?

to report allegations to the relevant local authority and the Care Quality Commission. We found that allegations of abuse since our previous visit had being dealt with appropriately in line with the provider's procedure.

The manager told us that all staff working at the home were expected to undertake training about safeguarding adults. We discussed this issue with the area training manager who provided us with details of staff training in the home. They told us that they had identified a shortfall in staff training about safeguarding adults and that it was planned that all staff would have this training by the end of October 2014. The training records indicated that of the 109 care and nursing staff that worked at the service four had not undertaken training about safeguarding adults and a further 23 had undertaken this training but were overdue to take it again. The expectation was that all staff would undertake safeguarding adults training on an annual basis.

Is the service effective?

Our findings

Staff we spoke with told us they received regular training to support them to carry out their roles effectively. They told us they had undertaken training in subjects which included dementia care, moving and handling, food hygiene, infection control, skin integrity and foot care. One member of care staff told us they thought they would benefit from end of life care training. The manager told us that the provision of this training was an area they had identified as a shortfall that needed to be addressed.

The area training manager told us that the service used an electronic system to monitor what training staff had undertaken and when they were next due to have any specific training. They told us that the provider considered some training to be a mandatory part of staff's employment. This included training about moving and handling, medication, pressure ulcer management, the use of bedrails and nutrition and hydration. Other training was provided to staff as appropriate. This included training about working with people with dementia. Training records showed that the vast majority of care staff had undertaken training about working with people with dementia.

Most staff told us they had regular one to one supervision meetings with a senior member of staff. They told us they found these meetings helpful and gave them the opportunity to discuss issues of importance to them. We examined staff supervision records which showed discussions about the needs of people, training requirements and good practice issues. One member of staff told us they did not have supervision because they thought they did not need it. We discussed this with the manager who told us that their expectation was that all staff should have regular supervision meetings. It was a concern that this issue had not been identified by the service.

At the time of our inspection the manager told us two people were subject to a Deprivation of Liberty Safeguards (DoLS) authorisation. We found that the service had followed appropriate procedure in applying for the DoLS authorisation and that they had notified the Care Quality Commission of the authorisations.

We found that people's nutritional needs were being met. Most people said they liked the food and they were provided with sufficient amounts to eat and drink. Comments included, "Good food, I've not gone hungry and if you are hungry you can go into the kitchen, there is always food there" and "They changed all the menus in the last few weeks, they are fair portions and it is not too bad." One person told us that the meal served on the day was difficult to eat because the meat was tough.

Staff told us people were offered a choice of meals and we observed this to be the case during our inspection. We spoke with kitchen staff that had a good understanding of people's dietary needs. The manager told us the menu had recently been updated in response to feedback from people who used the service and their relatives. They told us the new menu was more reflective of the cultural and ethnic background of people that used the service. Records showed that food was provided that reflected the various cultural and ethnic backgrounds of people. We saw that care plans included information about people's likes and dislikes with regard to food.

Care plans included risk assessments about managing the risks of malnutrition and dehydration. These showed that the service had involved health professionals including GP's, dieticians and speech and language therapists where people were assessed as being at risk. There were detailed assessments and plans on what type of food people should have for those who were diabetic. Guidance was provided to observe for signs of hypo or hyperglycaemia. This meant the service was seeking to meet people's nutritional needs in a safe manner.

Records showed people had access to health care professionals including GP's, tissue viability nurses, chiropodists and speech and language therapists. People confirmed that the service supported them to access health care professionals. One person told us, "The nurse called him [GP] and he sorted out my back with some ointment." Another person said, "The doctor comes once a week but if there is some serious need he will come." As part of this inspection we contacted various health and social care professionals to seek their views on the service. A tissue viability nurse told us, "The nurses seek tissue viability advice appropriately and are very proactive in trying to prevent pressure ulcers and risk assess all patients and are aware of what procedures to follow and attend training we do."

Is the service caring?

Our findings

People said that staff treated them with respect and enabled them to make choices over their daily lives. One person told us, "Before they wash me I ask if I could go and wash my face, neck and hands myself and dry myself. They then do the top half, they dry and talc me and then the bottom half they wash, and this is the female nurse who does this." Another person told us, "They do listen and privacy is respected. When my pad was changed the gentleman carer went out of the room and the girl changed it." We saw that if people had a preference for what gender their carer was this was recorded in peoples care plans. Staff we spoke with said that they always respected this. One person said, "They treat me well. So far I've had no complaints." Another person told us, "The carers make a point of being friendly." But added, "Some have an attitude when speaking, they raise the volume of their voice to get their point over. They could handle that better. I spoke to one of the sisters about it."

We observed that staff supported people in a caring manner. For example, we saw staff talked with people in a friendly and sensitive manner and they knocked on doors before entering people's bedrooms. Staff supported people in a caring manner. We saw two staff transferred a person from a wheelchair to an armchair. Staff supported the person to sit in the armchair until the person said they were in a comfortable position. Staff were seen to perform this task with kindness and patience. On another occasion two staff were seen to support a person to calm down when he appeared to be in an agitated state. We saw they gave him reassurance and stayed with him until he appeared calm and settled. However staff and people that used the service told us that there was not a lot of time to simply spend chatting with people as staff were too busy providing essential care tasks. We observed that this was the case during our visit.

Information we received from the provider before our visit told us about how the home had sought to meet people's individual needs. For example, where possible people's bedroom doors had been painted the same colour as the front door of their previous place of residence to help people identify their own rooms more easily. We found that bedrooms had been personalised to people's own tastes, for example with family photographs and their own possessions.

Staff told us that people and their relatives where appropriate were able to make choices about their end of life care. People were able to plan where and how they wanted this care to be provided. These decisions were recorded as part of people's care plans and we saw end of life care plans in the records we examined. For example, one end of life care plan stated that the person was to have the last rites administered by a priest and in another it provided information about what was to be done with the body after death.

We saw care plans were personalised and provided information about how to meet the needs of each individual. Staff we spoke with had a good understanding of people's individual needs and told us they were expected to read people's care plans. Staff told us how they promoted people's dignity. For example they told us they made sure doors were closed when providing personal care and by interacting with people in a polite and respectful manner. One member of staff said, "When washing people we shut the door and only you and the person is in the room and we knock before we go in and we explain what we are going to do fully, before we do it."

Is the service responsive?

Our findings

At the previous inspection of this service in March 2014 we found the service was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found that people had not always consented to the care provided and that where people lacked the capacity to give consent the service had not always involved relevant people in making decisions. During this inspection we checked to determine whether the required improvements had been made.

We found for the most part care plans were followed by staff. For example, where care plans relating to skin integrity said people had to be regularly repositioned we found completed turning charts in place. Where it was stated that people's fluid and food intake had to be monitored we found this was done. However, we found one instance where a person's care plan was not been followed that put them at potential risk. The person had a health care related issue. Their care plan provided clear guidance on how this was to be managed, which included carrying out regular checks and contacting the GP if their health deteriorated. Records showed the condition had deteriorated but the GP was not called. This meant the person was at risk because the service was not monitoring their health care needs in line with their care plan. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that care plans had been signed by people who used the service or their relatives where appropriate. Relatives we spoke with told us they were involved in planning care and making decisions for people where they lacked capacity to do so. For example, a relative told us they had been involved about a decision not to inform a person that another of their relatives had been unwell as it was felt this would have been too distressing for them. People's care records showed that the home had carried out mental capacity assessments. We found that where people lacked capacity meetings were held to agree decisions in the person's best interest. For example, we saw that a best interest decision to covertly administer medication to one person had been made which involved their family members and GP.

Training records showed that most care and nursing staff had undertaken training about the Mental Capacity Act (MCA) 2005. However, much of this training took place in 2009. Some staff we spoke with had a good understanding of the MCA and of the responsibilities it placed upon them but other staff had only a limited understanding of this issue. However, for the most part staff were able to tell us how they supported people to make choices and what they would do if a person lacked the capacity to make a decision.

Most people told us the staff knew how to meet their needs and said they were satisfied with the care provided. Comments included, "The staff listen to me, sometimes they are in a hurry, but if I need to go to the toilet they make time" and "They are very concerned for my needs." However, a relative told us that they felt their relative's needs were not always met, telling us, "He had on someone else's slippers, they were far too big for him."

Staff told us that before a person was admitted to the home a senior member of staff met with them and their relatives where appropriate to carry out a pre-admission assessment. This was to determine what the person's needs were and if the home was able to meet those needs. Care plans and risk assessments were then developed based upon the initial assessment.

The care plans contained detailed information about how to meet the individual and assessed needs of people. Care plans included information about people's needs in relation to communication, nutrition and hydration, skin integrity, moving and handling, personal hygiene and dressing and lifestyle, culture and social interaction. Plans were mostly up to date, but for one person the care plan on lifestyle, culture and social interaction was not completed. Staff we spoke with were unable to account for this.

Care plans were reviewed once a month or more often if required. Daily records were maintained which were linked to each individual element of the care plan which meant the service was able to monitor what progress had been made and what actions had been taken towards meeting people's assessed needs.

Staff told us that if there was a change to a person's needs this was discussed during a staff shift handover at the beginning of each shift. We observed part of the staff handover from the night shift to the morning shift. This entailed the senior night staff discussing each resident on their unit in turn to give an update on how they had been in the night and if there were any significant issues to report. The manager told us that the home held a weekly clinical

Is the service responsive?

meeting attended by the manager and the heads of each unit. These meetings discussed the needs of people with regard to clinical areas and how best to meet those needs. This helped to keep people's needs under review to enable the service to monitor and react to changing needs.

The provider had a complaints procedure in place which included timescales for responding to complaints received and details of who people could go to if they were not satisfied with the response from the service. The provider informed us that all complaints were dealt with within 28 days. They said that all complaints were recorded centrally and analysed for any patterns that emerged. For example, last year the service had three complaints about pressure ulcer management. The service purchased equipment to help reduce the risk of pressure ulcers and the issues were discussed with staff during supervision. The provider told us that as a result of this there has been a considerable improvement for people in this area.

People knew who they could complain to if required. A relative told us, "It is very good, I have never had cause to complain, if something is not right we have said something and it has been fixed. Two to three months ago they forgot to tell me about a hospital appointment. They were apologetic. It was an oversight." Another person told us, "If I have concerns then I speak to the nurse."

Is the service well-led?

Our findings

The service had a registered manager in place and a clear management structure. This included a deputy manager and each of the four units had a head of unit in charge. In addition there were clear management structures in place for other departments within the home such as housekeeping and kitchen and domestic staff.

We contacted the local authority commissioning team as part of our evidence gathering for this inspection. They told us they thought that, The management team is effective." and that they had various quality assurance and monitoring systems in place. We found that the quality manager of the provider carried out a monthly visit. We looked at the reports of two recent visits which showed discussions with staff and people who used the service and checking of various records. Action plans were included within the report detailing issues that needed to be addressed.

The home carried out an annual service user satisfaction survey. The report of the most recent survey was published in January 2014. The survey asked people to rate various elements of care and support within the home. The results we looked at were mostly positive. For example 97% of respondents rated staff respectfulness as excellent or good. The lowest score of the survey was only 72% of respondents said the staffing levels were good or excellent. In addition to the residents survey the home also surveyed relatives which broadly reflected the findings of the service user survey. The manager told us that the results of surveys were used to make changes and improvements. For example after the most recent surveys they held a meeting with relatives and residents to discuss the findings and as a result of that meeting it was agreed the service would provide more varied food choices especially for people from a non-English background. Records of menus showed this to be the case. We noted however, that despite the results of the survey staffing levels were still often below the assessed level of staff support needed.

The manager told us various audits were carried out. We examined some of these, including infection control audits and audits of medicines records. Either the manager or deputy manager carried out a daily 'walk around' to discus with staff if there were any issues or problems relating to medicines, accidents or incidents, or complaints.

In addition, the manager occasionally worked shifts in the home as a nurse on duty. This enabled them to see at first hand the issues that staff faced whilst carrying out their duties.

The manager told us one of the major achievements in recent months had been the reduction in the number of accidents and incidents. They told us this was because all accidents and incidents were subject to a thorough investigation which enabled the service to find out what went wrong and why. This in turn meant they were able to learn from this and take steps to prevent the same event recurring. For example, they told us this had helped to improve the care of pressure ulcers.

The manager also told us they felt they had created a more open environment in the home because people who used the service, their relatives and staff were encouraged to raise issues with management. Staff we spoke with agreed that this was the case. All staff we spoke with told us they were happy to raise any concerns they had with senior staff and that they found management to be approachable and accessible.

Staff meetings were held to help staff understand what was expected of them and to enable them to raise issues of importance. Care staff told us they had regular meetings on their units were they were able to discuss issues about the way the service was run or concerns regarding people's needs and support. There was also a daily 10 minute meeting with senior staff to discuss anything of great importance on that day. In addition the home had a monthly head of departments' meeting so issues about individual people could be discussed. For example, if there was a concern that a person was losing weight the relevant clinical staff could discuss this with the head of hotel services that had responsibility for kitchen staff.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 (1) (b) (ii) HSCA 2008 (Regulated Activities) Regulations 2010.** **People who use services and others were not protected against the risks associated with unsafe care and treatment because the planning and delivery of care and treatment was not carried out in a way to ensure the welfare and safety of service users.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010.** **People who use services and others were not protected against the risks associated with unsafe care and treatment because there were not always enough staff working at the service at all times to meet people's assessed needs.**