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Malvern House

Inspection report

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19 April 2016
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service in September 2015. At this inspection breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. 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.

This focussed inspection took place across two dates, 19 April and 28 April 2016. The first day of the inspection was unannounced. This means we did not give the registered provider prior knowledge of our inspection. The second day was announced. We also revisited the registered provider on the 16 May 2016 to give feedback of our inspection findings. We did this by prior arrangement.

Malvern House is registered to provide care and accommodation for up to 8 persons who have a learning disability, mental health needs or autistic spectrum disorder. The home is situated in Heysham close to a number of facilities and amenities. All accommodation at the home is provided on a single room basis and all of the bedrooms have en-suite facilities.

There was an individual registered provider in place. They became legally responsible for the home in June 2015. The registered provider manages the day to day running of the home. Registered providers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the comprehensive inspection of Malvern House in September 2015 the service was rated as 'requires improvement' overall, with 'requires improvement' ratings in two of the key questions 'is the service safe?' and 'is the service well – led?' We identified a breach of Regulation 12, (Safe care and treatment) as risks to a person who lived at the home were not managed safely. We also identified a breach of Regulation 13, (Safeguarding service users from abuse and improper treatment) as referrals to safeguarding authorities were not always made. In addition we identified a breach of Regulation 17, (Good Governance) as there were ineffective systems in place to identify, monitor and assess the risks relating to the health, safety and welfare of people who used the service. We further identified a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 as notifications to the Care Quality Commission were not always made.

We carried out this focussed inspection in April 2016 to check improvements had been made.

During the focussed inspection carried out in April 2016, we found risk assessments were not reviewed to ensure people received care and support which met their needs. In addition we found risks were not always suitably assessed and managed. This was a continued breach of Regulation 12, (Safe Care and Treatment).

We noted there were ineffective quality monitoring systems in place as areas for improvement had not been identified by the registered provider. This was a continued breach of Regulation 17, (Good Governance.)

We viewed care records to ascertain the care and support people received. We found information was sometimes difficult to find and there were gaps in some daily entries. In addition we noted care and support needs had not been fully documented to ensure staff knew people's care and support needs and the reasons for these. We further found there was no documented evidence of agreements made with people regarding the purchasing of essential items. This was a breach of Regulation 17, (Good Governance.)

We found best practice guidance was not implemented in relation to supporting people who are living with a learning disability. We have made a recommendation regarding this.

We found the principles of the Mental Capacity Act 2005 were not always followed. This was a breach of Regulation 11, (Need for Consent.)

The overall rating for this service is 'Inadequate' and the service is in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Risk assessments were not reviewed to ensure people received care and support which met their needs.

Risk assessments were not always in place to ensure people were not at risk of avoidable harm.

Is the service effective?

Requires Improvement

The service was not always effective

We found the principles of the Mental Capacity Act 2005 were not always followed. This meant people could not be assured their rights were protected.

Is the service well-led?

Inadequate

The service was not well-led.

Care records were not always up to date and information was difficult to find. Records were not in place to ensure people who lived at the home were aware of additional costs of living at the home.

The registered provider did not have systems in place to assess, monitor and identify if improvements were required.

The registered provider did not have systems in place to assess, monitor and mitigate risk relating to the health and safety and welfare of people who used the service. This meant people could not be assured the care and support they received met their needs.

Malvern House

Detailed findings

Background to this inspection

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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of Malvern House on 19 April and 28 April 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our September 2015 inspection had been made. The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well-led? This is because the service was not meeting some legal requirements. During the inspection we identified concerns within the question 'is the service effective?' Therefore we included this in our inspection.

This focussed inspection took place across two dates, 19 April and 28 April 2016. The first day of the inspection was unannounced. This means we did not give the provider prior knowledge of our inspection. The second day was announced. The inspection was carried out by two adult social care inspectors. We also revisited the registered provider on the 16 May 2016 to give feedback of our inspection findings. We did this by prior arrangement.

Following the comprehensive inspection carried out in September 2015, the registered provider sent us an action plan. This indicated the actions the registered provider planned to take to ensure improvements were made. We reviewed this as part of our inspection planning. In addition we reviewed notifications the provider had sent us, and reviewed information provided by the safeguarding authorities. We also received feedback from the local authority. This helped us plan our inspection effectively. At the time of the inspection we were made aware of an occurrence at the home. We are considering our response in relation to this.

During the focussed inspection we used a variety of methods to gather information. At the time of the inspection there were four people who lived at Malvern House. We spoke with three people who consented to talk with us. We also spent time in the communal lounge at the home. This was so we could observe interactions between people who lived at the home and staff. We spoke with two staff during the time at the

home and the registered provider. Following the inspection we spoke with one further staff member by telephone. We contacted three relatives of people who lived at the home. We did this to gain their views on the service provided.

During the inspection we reviewed five care records and also viewed staff rotas. We reviewed policies relating to risk management, financial records relating to a person who lived at the home and accident and incident records.

We also undertook a visual inspection of communal areas and two people gave us consent to look in their private rooms.

Inadequate

Is the service safe?

Our findings

At the focussed inspection carried out in April 2016, we identified risks to people who lived at the home were not consistently managed. Prior to the inspection we received information from the local safeguarding authority that people appeared to have lost weight. We reviewed the weight management records for five people and found dietary risk assessments were in place. We saw part of the risk assessment asked if there had been unintentional weight loss within the last three months. We discussed this with the registered provider. They told us they had initially carried out the risk assessments and people who lived at the home remained within the expected weight ranges.

We asked the registered provider if people were regularly weighed. The registered provider told us people were not. They explained this was because people who lived at the home were eating and drinking well. We asked the registered provider how they could be sure the risk to people had not changed if people were not weighed and risk assessments reviewed. The registered provider told us people who lived at the home had seen their GP's in March 2016 who had voiced no concerns. We saw an entry in the registered provider's diary which confirmed people had attended their GP and had been weighed.

We viewed one person's nutritional plan and risk assessment completed in August 2015. We noted the registered provider had recorded monthly monitoring and a weight chart was to commence. The weight chart we viewed showed the person had been weighed in August 2015 and April 2016. There was no evidence of weights being recorded in between. We were shown a risk assessment dated April 2016 for the person. The registered provider told us this was being introduced as the person's weight fluctuated.

We spoke with a person who lived at the home. They told us they had lost weight and had not intended to do so. We discussed this with the registered provider who told us they considered the person had a specific health condition. We viewed the person's care record and saw no specific risk assessment had been carried out to minimise the risk to the person. We asked if a referral to an appropriate health professional had been made to ensure the person was receiving appropriate care and treatment which met their needs. The registered provider told us it had not. They told us the person had not agreed to have a health referral made. They told us this had been discussed with the person's relative and this was recorded in the person's care record. We viewed the care record and saw an entry which recorded the relative had been informed of the person's health condition. Following the inspection we contacted the relative who told us the health condition had not been discussed with them.

This was a breach of Regulation 12 (Safe Care and Treatment) as the registered provider had not worked in a timely way to ensure care planning took place to ensure the safety of welfare of the person.

We spoke with one person who had restricted mobility. They told us if they needed assistance during the night they shouted for help. They explained they had had an intercom system in place but this had been removed. They told us they sometimes felt "panic" as they were worried if they became ill, staff would not hear them shouting. One staff member we spoke with confirmed the person had previously shouted for help if they needed assistance. We viewed the person's care record and saw no risk assessment in place to

manage the risk of the person requiring assistance at night without a suitable call system. We discussed this with the registered provider who told us the system had been removed as the person had not used it. Prior to the inspection concluding we were informed an appropriate system was in place.

We viewed the registered providers 'Risk Taking and Risk Management Policy.' We saw recorded that the registered provider would identify all potential risk. Risks would be recorded in the care records with an action plan. In addition we viewed the 'Risk Assessment Policy." This recorded the registered provider would identify and carry out specific risk assessments that were legally required. The policy documented they would carry out a detailed risk assessment on hazardous activities. In addition it recorded the registered provider would implement the control measures and further actions required to reduce the risk identified in assessments. The registered provider had not followed their risk management and risk assessment policies.

We saw documentation which recorded the registered provider had submitted a Deprivation of Liberty application to the local authority. The documentation we saw showed the application was submitted in October 2015. We noted the documentation also showed the person had left the home unaccompanied in March 2016 on two occasions. The person's care plan documented the person was to have staff support when leaving the home to minimise risk to themselves when in the community unsupported. We viewed an incident report and saw it recorded the person had distracted staff prior to leaving the home. Care and support had not been provided in accordance with the person's needs.

Within the care record viewed, we saw written entries that indicated the person had experienced difficulties with their mobility. We viewed an accident form which recorded the person had been found on their floor. In the care record we viewed we could see no risk assessment in place to assess the risk or any documented risk control measures to mitigate the risk.

At the time of the inspection these were a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe Care and Treatment) as risk assessments were not always reviewed, risks were not always assessed and safe care and treatment was not always delivered. This placed people at risk of unsafe care and support that did not meet their needs and placed them at risk of avoidable harm.

During the inspection carried out in September 2015 we identified a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safeguarding service users from abuse and improper treatment.) We found the registered provider had not informed the local safeguarding authority of any safeguarding incidents as they had occurred.

During this focussed inspection we saw two separate incidents had occurred at the home and we checked these had been reported appropriately. We contacted the local safeguarding authorities. Lancashire safeguarding authorities confirmed these had been raised with them by the registered provider.

We discussed staffing with the registered provider. They told us they worked at the home in addition to the member of care staff on duty. They explained they were currently utilising agency staff to cover planned leave. In addition they told us some staff had left employment. They explained the agency staff bookings were made in advance and were for the duration of the long term leave. They said they were aware this may have an impact on the care provided. We looked at the rotas for the home and saw some staff changes had occurred. Over a four and half month period we saw five staff members were no longer working at the home. The registered provider explained two members of staff were on planned leave. Two of the relatives we spoke with voiced concerns regarding the staffing arrangements at the home. They explained they felt their family member required staff who knew their needs well to enable them to live fulfilling lives. We discussed

this with the registered provider during our feedback visit. The registered provider told us agency were used to cover planned leave. They explained the agency staff were supported by permanent staff to enable them to learn about people who lived at the home.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

During this focussed inspection one person told us they had lost weight and had not intended to do so. We discussed this with the registered provider who told us they considered the person had a specific health condition. We were also informed the person had not agreed to a referral to an appropriate health professional being made. The registered provider further informed us this had been discussed with the person's relative.

In the care record we viewed we saw an entry which recorded this had been discussed with the person's relative. There was no documentation to evidence the mental capacity of the person had been assessed to ascertain if they were able to make an unwise decision.

During the inspection we wrote to the registered provider and requested evidence of mental capacity assessments for each person at Malvern House between 16 June 2015 and May 2016. This was provided promptly. The documentation we received showed the registered provider had assessed the person's capacity in April 2016. This was following the person's decision not to be referred to another health professional and the recorded conversation with the person's relative.

In addition the documentation we received showed the capacity assessments in relation to decisions three other people had made, had not been completed until April 2016.

This was a breach of Regulation 11, (Need for consent) as the registered provider had not ensured decisions were made in accordance with the MCA 2005.

Inadequate

Is the service well-led?

Our findings

During the comprehensive inspection carried out in September 2015 we identified a breach in Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. It is a legal requirement providers notify the CQC without delay of any allegations of abuse, however there was no evidence to demonstrate this had been done.

During this focussed inspection carried out in April 2016 we found improvements had been made. Prior to the inspection we reviewed the information the CQC holds about the registered provider. We found evidence that notifications had been submitted to the CQC as required.

During this focussed inspection in April 2016 we identified improvements were required to the care records at the home. We reviewed two care records in detail and found these were not contemporaneous. For example we saw there were missing entries in the daily entries records of two people who lived at the home. One care record had 12 missing daily entries between 30 September 2015 and 14 February 2016. The second record had 20 missing daily entries between September 2015 and April 2016. The lack of accurate and complete care records placed people at risk of care and support that did not meet their needs as information was not availiable.

We also saw information in records was sometimes difficult to find. For example we saw information contained on the 'Summary of appointments sheet' was not always reflected in the daily entries. We saw an entry on the appointments sheet recorded a person had spent time with a relative. This was not reflected in the daily entries. We saw two entries on a finance record that recorded money was given to the person to enable them to carry out a social activity outside the home. The daily entries and the appointment sheets did not reflect the activity had taken place. We also noted an incident of a person leaving the home unaccompanied was not recorded in the daily care records until ten days after the incident occurred.

In a further care record we saw one person had behaviours that may challenge either themselves or those around them. We saw the person was described as, 'confused' and there were numerous entries which showed they got up at night and walked around the home. We viewed an accident and incident report which recorded the person had sustained an injury and was 'wandering and not sleeping at night.' The accident form showed the registered provider had recorded the person was at high risk of injuring themselves. We noted the registered provider had also recorded staff were to encourage the person to relax. In the care record we viewed we could see no care plan or risk assessment in place to instruct staff in the action to take to ensure the person's care and welfare.

We discussed this with the registered provider who told us they had requested a reassessment of needs from the appropriate health professionals and had provided additional staff to support the person. They also told us staff were aware of the support the person required. In the same care record we saw the person had a change in health needs. We saw three entries in the daily care records which recorded the person needed support to eat. There was no care plan in place to instruct staff on how the person was to be supported or the reason for this. The registered provider was unable to discuss this.

We discussed the provision of toilet rolls with the registered provider. The registered provider said these were provided by them in communal bathrooms, however in en-suite bathrooms, people who lived at the home were expected to buy their own. We also discussed a cleaning product. The registered provider told us a person who lived at the home bought their own cleaning product. This was because they had specific needs. In the five care files we viewed we did not see agreements in place which demonstrated this had been discussed and agreed with people who lived at the home. During our feedback visit we discussed this with the registered provider. The registered provider showed us a 'service user agreement' which showed toiletries were now included in the 'service user agreement.'

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance) as an accurate record in respect of the care and support agreed and provided was not in place. This placed people at risk of care and support that did not meet their needs.

In the care documentation we viewed we saw no evidence best practice guidance was implemented. For example we saw no evidence 'Health Action Plans' were in place. Health Action plans are recommended by the Department of Health for people who are living with a learning disability. A Health Action Plan is a personal plan which lists any support people may need in order to stay healthy.

We recommend the registered provider seeks and implements best practice guidance in relation to supporting people who are living with a learning disability.

During the comprehensive inspection carried out in September 2015 we identified a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance.) The registered provider did not have effective quality assurance systems in place to identify where quality and safety was compromised. Systems were not in place to safeguard all people against risk and ensure appropriate care was delivered to meet individual needs.

During this focussed inspection carried out in April 2016 we found improvements were required to ensure accurate records were kept and risk assessments were reviewed and updated. We asked the registered provider if they carried out any checks on the quality of the care records. The registered provider told us they carried out checks on daily records for accuracy. As the evidence in this report demonstrates, the provider did not have effective quality assurance systems in place to identify if improvements were required.

This was a continued breach of Regulation 17, (Good Governance.) The provider did not have effective systems in place to assess, monitor and improve the quality of the services provided or assess monitor and mitigate risk relating to the health and safety and welfare of people who used the service.