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

Summary of findings

Overall summary

When we last inspected this service in July 2014 we found two breaches of regulations. This was because there were not always enough staff working at the service to ensure people's safety and treatment was not always given in a safe manner. At this inspection we found improvements had been made and that they now met the previous legal breaches.

The home provided accommodation with nursing and personal care for up to 120 adults. At the time of our inspection 115 people were living at the service. The home was divided into 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. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff did not always have access to appropriate training, in particular with regard to dementia training.

We found one breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

There were enough staff working at the service to meet people's needs in a safe manner. Checks were carried out on new staff before they began working at the service. Risk assessments were in place which included information about how to mitigate any risks people faced. Staff had undertaken training about safeguarding adults and were aware of their responsibilities for reporting any allegations of abuse. Medicines were managed appropriately. Safety checks were carried out at the service including fire safety checks.

Staff had access to regular training and supervision. The service operated within the Mental Capacity Act 2005 and people were supported to make choices where they had capacity to do so. This included choices about what people ate and drank and people told us they were happy with the food provided. People had access to health care services as required.

People and relatives told us staff behaved in a caring manner and that people were treated with respect. Staff understood how to promote peoples dignity.

People were involved in developing their care plans which were regularly reviewed. People had access to various activities. People knew how to make complaints and complaints were responded to appropriately.

People that used the service and staff told us they felt the management team was open and supportive. The

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

Care plans did not include sufficient information about people's life history and their likes and dislikes and we made a recommendation about this.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. There were enough staff working at the service and checks were carried out on prospective staff, including criminal record checks.

Risk assessments were in place which set out how to support people in a safe manner. Staff told us the service did not use physical restraint or intervention when working with people who exhibited behaviours that challenged the service.

Systems were in place to protect people from the risk of abuse. Staff knew their responsibilities with regard to safeguarding and the service acted appropriately when any allegations of abuse were made.

Medicines were managed safely. The service carried out various safety checks in the home including fire safety checks.

Is the service effective?

Requires Improvement

The service was not always effective. Although staff had access to regular training, many staff were not up to date with training in dementia care although the home was a specialist provider of dementia care.

People were supported to make choices and where they laced capacity the home operated within the Mental Capacity Act 2005.

People were provided with sufficient amounts of food and were able to choose what they ate and drank.

People had access to health care professionals as required.

Is the service caring?

Good

The service was caring. People told us they were treated in a caring way by staff. We observed staff interacting with people in a polite and friendly manner

Staff had a good understanding of how to promote people's choice, privacy and independence.

Is the service responsive?

Requires Improvement

The service was not always responsive. Although care plans were in place for people these often contained only very basic information about the person's past life history and their likes and dislikes.

People told us they knew how to make a complaint. Records showed that the service responded to complaints appropriately.

Is the service well-led?

Good

The service was well-led. There was a registered manager in place and people and staff told us they found management to be helpful and supportive.

The service had various quality assurance 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

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.

This inspection took place over two days on the 6 and 7 April 2016 and was unannounced. The inspection team consisted of two inspectors, a specialist pharmacy inspector and a specialist with a background in nursing and dementia care.

Before the inspection we reviewed the information we already held about the service. This included details of its registration, previous inspection reports, safeguarding alerts and statutory notifications sent to us by the provider. We contacted the local authority with responsibility for commissioning care from the service to gain their view.

During the inspection we spoke with eight people that used the service and seven relatives who were visiting the home during the course of our inspection. We spoke with 22 staff; this included the registered manager, the administrator, the clinical services manager, the chef manager, six nurses, nine care assistants, two activities coordinators and the maintenance manager. We observed how staff interacted with people. We looked at 18 sets of care records including care plans, risk assessments and treatment records. We looked at eight staff recruitment, supervision and training records. We viewed various audits at the service and looked at policies and procedures including the safeguarding adults and complaints policies.

Good

Is the service safe?

Our findings

At the previous inspection of this service in July 2014 we found the service did not always have enough staff on duty to meet people's needs in a safe manner. During this inspection we found this issue had been addressed.

The registered manager told us they had over-recruited staff so that it was now easier to book a staff member to cover a shift at short notice. They also told us that any staff sickness was discussed with the individual staff member

Most staff we spoke with said there were enough staff. One staff member said, "The staff level is good." Another staff member told us, "Staffing levels are quite good. Most of the time we are able to get staff cover [if a staff member is off sick]." They told us occasionally they were short staffed and staff worked together as a team to compensate for this. The clinical services manager told us that the lead member of staff on each unit had the authority to book extra staff themselves if they were short staffed on any given shift. Lead members of staff on the units on the days of our inspection confirmed this was the case. The clinical services manager said that about once a month they were not able to get staff to cover a shift and on those occasions they worked as a nurse on duty.

People told us there were enough staff. A relative said, "I think so" when asked if there were enough staff on duty. We observed that staff had enough time to carry out their duties and support people in a timely manner during the course of our inspection.

There were effective recruitment and selection processes in place as staff personnel records showed they had been subject to appropriate and necessary checks prior to being employed by the service. We saw that copies of proof of identity, their application form, which included their employment history, were kept on file. Criminal record checks were carried out to confirm that newly recruited staff were suitable to work with people. We saw that references had been obtained to ensure people were of good character and fit for work. Records also showed that staff's nursing registration and visa status where relevant had been monitored on a regular basis to ensure they were eligible to practice or work. One staff member told us, "I could not start until my references and DBS were received."

People using the service told us it was safe. One person said, "It's excellent. All my needs are met. To me it's safe." A relative said, "[Person that used the service] can't come to any harm. I feel she is safe and well looked after."

The service had safeguarding policies and procedures in place to guide practice. Staff told us they had received training in safeguarding adults. Staff understood what abuse was and how to respond appropriately if they suspected that people were being abused. Staff knew about whistleblowing procedures and who to contact if they felt concerns were not dealt with correctly. The registered manager demonstrated that they had made safeguarding referrals to the local authority and the Care Quality Commission (CQC) and acted appropriately following incidents of suspected abuse. One senior staff

member told us, "I have to inform my line manager and raise a safeguarding."

Risk assessments were in place for people which included information about how to mitigate and reduce risks people faced. For example, the risk assessment for one person on mobility and moving around stated, "Staff should look out for clear walking ways free from hazards and obstacles. Staff to make sure [person that used the service] is wearing appropriate shoes that are flat and fit well. Keep [person that used the service] Zimmer frame next to them for their comfort. Make sure the sensor mat is working in their bedroom as they have a history of falls."

We saw that Waterlow assessments were in place for each person. These are risk assessment tools used to determine the level of risk a person faced with regard to skin integrity and the risk of developing pressure ulcers or other skin wounds. Where people were assessed as being at risk a care plan was devised in order to reduce the risk.

The registered manager and other staff told us they did not use any form of physical intervention when working with people to restrain them. Staff told us how they supported people who were anxious by trying to de-escalate the situation, for example by seeking to divert their attention and giving people space and time. The home did use bedrails with some people. Where they were in place mental capacity assessments and risk assessments had been carried out to help ensure their safe and appropriate use.

Appropriate arrangements were in place for obtaining medicines. Staff told us how medicines were obtained and we saw that supplies were available to enable people to have their medicines when they needed them. As part of this inspection we looked at the medicine administration records. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed people were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving people their medicines were recorded.

When medicines were prescribed to be given 'only when needed', or where they were to be used only under specific circumstances, individual when required protocols, (administration guidance to inform staff about when these medicines should and should not be given) were in place. This meant there was information to enable staff to make decisions as to when to give these medicines to ensure people were given their medicines when they needed them and in way that was both safe and consistent.

Medicines were stored securely. Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use. Controlled drugs were stored and managed appropriately. Where the provider carried out daily stock checks and monthly audits to check the administration of medicine was being recorded correctly. Records showed any concerns were highlighted and action taken. This meant the provider had systems in place to monitor the quality of medicines management.

The service carried out various maintenance and safety checks. For example, wheelchairs and bedrails were checked each month to make sure they were working properly. Systems were in place to promote fire safety including checking alarms and lighting. Other safety checks included gas, electrical installation and portable electrical appliances within the home.

Requires Improvement

Is the service effective?

Our findings

The registered manager told us that all staff undertook training about dementia care as part of their induction and then the expectation was that all staff would have an annual refresher training course in dementia care. Records showed that 94% of staff had received their mandatory training about dementia care on commencing work at the service. However, records showed that only 61% of staff were up to date with their annual refresher dementia training and the registered manager confirmed this was the case. They explained that this training was provided in-house and they had only very recently trained staff so that they were competent to provide the dementia training to the rest of the staff. They said they anticipated that all staff would be up to date with dementia training by the end of October 2016.

We looked at the supervision and annual performance and development review records of eight staff. We found that of the seven staff that had worked at the service for over a year only five had undertaken an annual review of their performance and development. The registered manager told us that all staff were expected to undertake such a review. There was no system in place for monitoring which staff had undertaken an annual review. The registered manager said they would introduce a system for this.

Lack of staff training about dementia and all staff not undertaking a review of their performance and development needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received regular formal supervision and we saw records to confirm this. The registered manager showed as a supervision matrix. One senior staff member said, "I give supervision to staff on the unit every two to three months." Recorded supervision topics included discussions on accidents and incidents, pressure ulcers, record keeping, infection control, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), training and bedrails.

Staff told us and records confirmed that they had received training in a range of topics relevant to their role. These included food hygiene, behaviours that challenged the service, complaints, fire safety, infection control, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), nutrition and safeguarding. One staff member told us, "All of us get training. [Registered manager] sends a copy of when training is due for staff." Another staff member said, "They make sure that we get enough training so that we can be competent." Another staff member said "She [registered manager] always encourages us to go for training courses."

New staff had been provided with induction training so they knew what was expected of them and to have the necessary skills to carry out their role. One staff member told us, "I did a full week induction which included health and safety, fire training and medication. I had to do these trainings before I could start on the unit." The same staff member said, "I had shadowed for a week. I had to shadow as I didn't know the residents."

People told us that staff understood how to meet their needs. One person said, "Staff are very friendly. Some

are skilled in what they are doing."

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

People can only be deprived of their liberty to receive care and treatment 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).

One the first day of the inspection the registered manager told us that DoLS authorisations were in place for 31 people using the service and that they had not notified the Care Quality Commission (CQC) of these authorisations. The registered manager told us they were aware of their legal responsibility to notify CQC of any DoLS authorisations. On the second day of our inspection the registered manager told us they were in the process of submitting the required notifications to CQC. CQC received the notifications the day after our inspection.

We found that the service had carried out Mental Capacity Assessments for people to determine if they had capacity to make specific decisions, such as consenting to take medicines or be supported with personal care. Where people were assessed as lacking capacity best interest decision meetings were held. These involved the person and their family members. We found that capacity was assessed and decisions made about people who lacked capacity was done in line with legislation.

People had signed consent forms to agree to share information with others. They were able to indicate who if anyone they were happy to share information with. For example, one person said they only wanted their information shared with their next of kin and professionals but not other family members.

People told us they liked the food and they were offered choices about what they ate and drank. One person said of the food, "It's not bad, I get what I want. Another person said, "It's lovely food."

We saw that a community dietician and nutrition specialist was present at the service during our inspection. They were there to provide training to staff about nutrition and hydration. They told us the home made appropriate and timely referrals for people who needed support around nutrition and that staff were knowledgeable about the people they supported.

Risk assessments were in place relating to people's risk of malnutrition and dehydration. We saw that people's weight was monitored on a monthly basis or more often if there was a higher risk. Where people were at risk of malnutrition we saw the service had made referrals to the GP and dietician services.

People were able to make choices about what they ate and drank. With each meal two main courses were provided. We saw staff asked people their preferences and where appropriate they showed people the two meals to help them make their choice. There was also a vegetarian option available. One staff member said, "We have so many food choices and we ask them what they like." Another person said, "We have one person who likes his own cultural food and we make it for him." The chef manager told us that if people did not want either of the two choices people were able to have something else. They said this was only restricted by what ingredients they had in stock.

People and their relatives told us they had access to health care professionals. One person said, "Whenever I become sick they give me medication. The doctor comes in." A relative said, "They had the physiotherapist in to see him." Another relative said, "The GP comes twice a week as a routine."

Records confirmed that people had access to health care professionals including GP's, opticians, physiotherapists and dieticians. Records included information about what the appointment was for and of any follow up action required.

We saw various health care professionals were visiting the service during the course of our inspection including a GP, a rehabilitation support officer and a physiotherapist. Health professionals we spoke with did not raise any concerns about the service and told us that staff were supporting people appropriately with regard to their area of specialism.

Good

Is the service caring?

Our findings

People and their relatives said staff treated them in a caring and respectful manner. One person said, "Staff are excellent, they are caring." Another person told us, "They [staff] are very good, they treat me fine. I don't have any trouble." A relative said, "I think they treat him very well, we have no complaints." Another relative said of the staff, "They are very friendly and very warm." Another relative said, "They do treat her well."

During the inspection we observed staff supporting people in a caring and sensitive manner. For example, we observed staff supporting a person to get out of an armchair and use a frame to get to their room. The person showed some anxiety doing this and staff gave gentle re-assurance to them and clear directions to the person on what to do to achieve the task in a safe manner.

People's privacy was respected. We saw on one person's care plan that they preferred to keep their bedroom locked and liked to wear the bedroom door key around their neck. We observed that the person did have their key around their neck. Staff told us they knocked on doors before entering bedrooms. One staff member said, "Before you enter the door, knock." Another staff member said, "Every time we give them care we make sure the door and curtains are closed." We observed that staff did knock on bedroom doors then made sure they were closed before they supported people with any personal care.

Care plans included information about promoting people's independence. Each element of the care plans had sections on what the person was able to do for themselves and what areas they required support with. For example, the care plan for one person stated, [Person that used the service] is able to dry the skin on the top part of their body when staff are assisting with personal care." The care plan for another person stated, "[Person that used the service] can brush his teeth and hair and dress himself with minimal assistance. He can choose his own clothes." A staff member described how they gave people choices and promoted their independence when providing support with personal care, telling us, "When [person that used the service] is in the bath I ask her if she can wash her hands and face." The same staff member added, "You have to ask their permission, you can't just do things." Another staff member said, "We ask them what they want. If they say they don't want a wash we try to encourage them to have one" but added that they respected the person's wishes. Another staff member said, "The most important thing is communication, you have to communicate with them." People told us they were able to choose what gender their care staff were who supported them with personal care and we saw this information was recorded on care plans.

We saw people were supported to have freedom of worship. The care plan for one person said they liked to go to a place of worship every week and records showed this happened. The registered manager told us representatives from two religions visited the home to support people with their spiritual needs and we saw one this on the day of inspection. Other people were supported to pray in their bedrooms in line with their religious preferences.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us they were happy with the care and support provided. One person said, "It's impressive, I have made progress." A relative said, "It's been first class care, [person that used the service] is much improved." They said the service was responsive to their concerns, telling us that they informed staff at the home that their relative needed a different type of chair to reduce the risk of falls and the service arranged that.

A nurse told us about the assessment process they carried out with people prior to them moving into the service. They said they met with the person to discuss what was important to them and what areas they required support with. The nurse said this assessment included discussions with health and social care professionals involved in the person's care and with family members where appropriate. They told us they then made a recommendation to the registered manager about whether or not to offer the person a place at the home. This recommendation was based on the assessment and if the nurse believed the service was able to meet the person's needs. They told us on occasions they had recommended that the service was not suitable for a person and that the registered manager had always accepted their recommendation, telling us, "So far they have never overruled me."

Care plans were in place which contained information about how to support people. They covered various elements of people's care including eating and drinking, personal care and toileting, senses and communication and mental health and wellbeing. We found that care plans were reviewed on a monthly basis. This meant they were able to reflect people's needs as they changed over time. Staff told us care plans were developed in conjunction with people that used the service. One person said, "They [staff] will put the care plan in front of me and ask me if any problems with it."

One the first day of our inspection we found instances of care plans that did not contain all required information. For example, one care plan did not include details about upper safe blood pressure levels for a person who was at risk of high blood pressure. The care plan for another person did not include sufficient detail about supporting them with behaviours that challenged the service. We discussed these issues with the registered manager and found that the care plans had been updated by the second day of our visit so they contained the relevant information.

People had access to various activities. For example, the care plan for one person stated they liked to attend Zumba classes at a local day service and records confirmed this activity took place. We observed people taking part in various activities during the inspection. For example, one staff member was conducting a quiz with people and another staff member was leading a drawing session with people. People were engaged in these activities and appeared to be enjoying them. A relative told us they were happy with the level of activities provided, saying, "They [staff] take them out on trips." The service employed four activities coordinators so that one was based on each unit. The activities coordinators told us they did a mix of group activities and one to one activities with people. For example, they told us one person liked poetry but was no longer able to read it themselves so the activities coordinator sat with them and read poetry. They told us several people had recently been supported to go out for lunch to a nearby public house.

The service had a complaints management policy. We saw the records of 12 complaints for the last 12 months. We found the service was listening to people's and their relatives' problems and concerns. Complaints were investigated appropriately and the service aimed to provide resolution for every complaint in a timely manner. For example, meetings were held with people's relatives to further discuss their concerns and to find a solution. One relative told us, "I would raise with the unit manager and escalate to the manager." Another relative said, "If I have an issue I would bring it up."

Most of the care plans we looked at contained only brief and basic information about people's life history. For example, care plans included a section titled, "My Day, My Life, My Story". These contained details of the person's next of kin, their GP, medical history and a brief description of their care needs. However, they gave very little information about the person's life before they started using the service. For example, sections on previous employment often only said a job title and information about where the person had lived just named one town. There was also only very basic information about their family members or their interests. For example, in the section titled 'Hobbies and Interests' for one person it simply said 'watching television' without any information about what type of programmes they most enjoyed. We discussed this issue with the registered manager who agreed that more personal information about people would help staff to get an understanding of the person and to build good relationships with them. The registered manager told us they had the service had begun to produce more detailed life histories for people and they were able to show us one care plan that reflected this. We recommend that care plans contain more personalised information about people's life history and their likes and dislikes to aide staff build relations with people.

Good

Is the service well-led?

Our findings

The service had a registered manager in place and there was a clear management structure at the service. The registered manager was supported by a deputy manager and a clinical services manager in the running of the home. Each of the four units had a head of unit and there were leaders of other teams, for example the team that oversaw catering, laundry and cleaning services within the home.

Staff spoke positively about the management and about the working atmosphere and culture at the service. One staff member said, "[Registered manager] is approachable, I am able to go to her." The same staff member added, "It's a good team." Another staff member said of the registered manager, "She is always on her toes and ready to support us, she is a lovely lady." The same staff member said of the management team, "I feel well supported by them, I am learning more from them." Another staff member said "The [senior staff] do listen." Another member of staff said, "The unit manager is a very diligent manager and I can talk to her if there are any problems." Another member of staff told us how the unit manager had supported their development, telling us, "I had a bit of a challenge in writing reports and she [unit manager] gave me a lot of advice about writing them in the proper way."

The service employed a registered nurse as a clinical services manager who was responsible for taking a clinical lead within the service along with the registered manager. They told us they carried out a daily 'walk around' of all four units in the home. This involved checking if there were any significant issues on a unit that day such as a safeguarding incident, death of a person, hospital admissions or discharges. This was to help ensure that the unit had plans in place to deal with anything. They told us they also checked staffing levels during the walk about and sought to arrange staff cover if required. They told us they also checked three care plans on each unit every month to make sure they were fully completed and that they had been reviewed within the past month and we saw records of this.

In addition, the registered manager also carried out a daily walk around and we saw records of this. They said this gave people that used the service the opportunity to talk with them and raise any issues they had. They also carried out a weekly walk around which included looking at maintenance issues. A recent walk around revealed that some of the net curtains were of poor quality and these were subsequently replaced.

The service had a daily 'take ten meeting' coordinated by one of the senior staff. This involved a representative from each of the departments in the home meeting briefly to discuss any important issues of the day and what was planned. Clinical meetings took place for nursing and senior care staff. The clinical services manager told us these meetings gave staff the opportunity to discuss ideas about best practice when working with individuals and meeting their clinical needs. In addition to these quarterly meetings were held for nursing staff from across the service.

The registered manager told us various audits were carried out. For example, 10% of all care plans were audited each month and regular medicines audits were carried out within the service.

Staff told us they attended staff meetings for the staff on the unit they worked on. One staff member said of

the meetings, "We talk about how to work with the residents, to make sure we monitor them." Another staff member said of the meetings, "We talk about residents and how we can support each other to work as a team. They are helpful and allow us all to speak." Records confirmed that various staff meetings took place in line with what staff told us. Minutes included discussions about clinical issues and team working. We saw some meetings were used as a learning and development exercise, discussing various topics including safeguarding and whistleblowing, DoLS and complaints handling.

The service held joint meetings for people that used the service and their relatives. One relative said, "We have meetings for relatives. The manager of the home comes and we can talk about any problems." Minutes confirmed these meetings took place which included discussions about menus, activities and laundry.

Staff and relatives of people told us they were invited to take part in a staff survey, one staff member said, "We did one last year." A relative said, "There was a form they wanted us to fill in, his daughter is doing that."

The provider carried out checks at the service in addition to those done by staff working within the home. The area manager and quality manager for the provider carried out six monthly visits to the service. These were followed up by monthly visits to check on progress made at any issues identified at the six monthly visits.

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 18 HSCA RA Regulations 2014 Staffing The registered person must ensure that sufficient numbers of suitably skilled and competent people are employed and they must receive appropriate training and development and appraisal as is necessary to enable them to carry out their duties. Regulation 18 (1) (2) (a)