Four Seasons (No 7) Limited

# Morecambe Bay Care Home

## Inspection report

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08 September 2016

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| Is the service safe? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

Morecambe Bay Care Home consists of four self-contained units, catering for a range of people with differing abilities. The service caters for people with disabilities, older people with nursing care needs and older people with residential care needs. At the time of the inspection there were three units providing care and support to 65 people living at Morecambe Bay Care Home.

We carried out an unannounced comprehensive inspection of this service on 29 February 2016 and 02 March 2016. At this inspection a breach of legal requirements was found. After the comprehensive inspection, the registered 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 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 Morecambe Bay Care Home on our website at www.cqc.org.uk

This focussed inspection took place on the 01 and 08 September 2016. The first day was unannounced. This means the registered provider did not know we were inspecting the home on this day.

At the time of the inspection there was a registered manager who was registered with the Care Quality Commission. Prior to the inspection we were informed by the registered provider that the registered manager had ceased employment at the home. We were also informed an acting manager who was familiar with the home would be overseeing the management of the service.

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.

At the comprehensive inspection of Morecambe Bay Care Home in February and March 2016. We identified a breach of Regulation 12, (Safe care and treatment) as medicines at the home were not managed safely.

We carried out this focussed inspection in September 2016 to check improvements had been made. During the focussed inspection we found people using the service were not fully protected against the risks associated with the administration, use and management of medicines. People did not always receive their medicines and creams at the times they needed them or in a safe way. This was a continued breach of Regulation 12 (Safe Care and treatment.)

You can see what action we told the provider to take at the back of the full version of the report.

We viewed care records to check the care and support people received. On the first day of the inspection we noted care records did not always contain accurate and sufficient information to ensure people's needs were met. We raised concerns with the acting manager. On the second day of the inspection we saw action had been taken to rectify this. We have made a recommendation regarding this.

We received mixed feedback about the service provided by Morecambe Bay Care Home. People told us they were happy living at Morecambe Bay Care Home and they found staff to be kind. People we spoke with described staff as, "lovely", "caring", and "brilliant". However people also described staff as "busy." And, "worn out." They told us if they required support, staff came quickly as they could. On the day of the inspection we observed staff to be rushing between tasks.

We spoke with staff about staffing levels. Two staff raised concerns with the number of staff available to meet people's needs. Staff told us if unplanned leave was taken the management at the home provided additional staff whenever possible; however there were occasions when this could not be provided. We have made a recommendation regarding 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?

**Requires Improvement**

The service was not always safe.

We found improvements in medicines management had not been made. People could not be assured they would receive their medicines safely.

People told us they considered more staff were required and some staff voiced their concerns regarding the number of staff available to meet people's needs.

We could not improve the rating for 'is the service safe?' as improvements had not been made.

### Is the service well-led?

**Requires Improvement**

The service was not always well-led.

People who lived at the home, staff and relatives told us the management team were approachable.

Care records required further information to ensure people's needs were documented.

# Morecambe Bay Care 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.

We undertook an unannounced focused inspection of Morecambe Bay Care Home on 01and 08 September 2016. This inspection was done to check that improvements to meet legal requirements planned by the registered provider after our February and March 2016 inspection had been made. We inspected the service against one of the five questions we ask about services: 'is the service safe?' This is because the service was not meeting some legal requirements.

During the inspection we identified some concerns within the question, 'is the service well-led?' and included this within our inspection.

This inspection was carried out by an adult social care inspector. Following the comprehensive inspection carried out in February and March 2016, the registered manager sent us an action plan. This indicated the actions the registered manager planned to take to ensure improvements were made. We reviewed this as part of our inspection planning.

In addition we reviewed information the Care Quality Commission holds about the home, notifications the registered provider had sent us, and reviewed information provided by the safeguarding authorities. This enabled us to plan our inspection effectively. We noted concerns had been raised regarding the availability of staff at Morecambe Bay Care Home. Therefore, we included this within our inspection.

During the inspection we spent time in each of the units at the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with ten people who lived at the home and two relatives. We spoke with a range of staff at the home. This included the registered provider, the quality clinical manager, the acting manager and the

regional manager. Other staff we spoke with included sixteen care staff, the administrator, the chef and the senior house keeper. We also spoke with three registered nurses who were employed by an external nursing agency and one registered nurse who was employed by the registered provider.

As part of the inspection visit we walked around the home to check suitable care was being provided. In addition, we viewed a range of documentation. This included five care records and a sample of medicine and administration records (MARS). We also looked at staff duty rotas, records of staff hours worked and three staff files.

Requires Improvement

# Is the service safe?

## Our findings

At the comprehensive inspection carried out in February and March 2016 we found medicines were not managed safely. People were at risk of not receiving their medicines safely and in accordance with their needs. This was a breach of regulation 12 (Safe care and treatment.) We issued a requirement notice requiring the registered provider to become compliant with the regulation. Following the inspection visit we were provided with an action plan from the registered provider telling us how they would comply with the regulation.

At the focussed inspection carried out on 01 and 08 September 2016 we found improvements had not been made to ensure people received their medicines safely.

We spoke with a nurse, a senior care worker and two members of the senior management team about medicines management within the home. We looked at medication stocks, Medication Administration Records (MARs) and other records for 16 people who lived at the home and found concerns and/or discrepancies in each case. We also spoke with four people who lived at the home about their medicines.

Two people who lived at the home told us prescribed creams were not always readily available for usage. One person told us they had asked staff, "At least 10 times" for a cream for their sore skin, but none had been obtained. We followed this up with the care worker on duty who immediately ordered it. Another person told us they were also waiting for a new cream for a skin infection. The nurse on duty told us the cream had been unavailable due to a manufacturing problem; however staff had taken no action to contact the GP for an alternative product .This meant the person's treatment had been delayed by six days resulting in sore, irritated skin.

Other people had not received their topical medicines correctly. We found one person had two sealed bottles of medicated shampoo and four unopened bottles of a lotion for psoriasis in their room. The shampoo should have been used once a week but was not listed on the current MARs, whilst the lotion was recorded as being used twice a day. The care worker who regularly supported this person told us they had never used either of these products. Two other people also had supplies of creams that had previously been prescribed for them in their rooms that were no longer listed on their current MARs. Care workers said these products weren't used, but did not know whether they had been discontinued or not.

The nurse on duty told us although external products were applied by care workers, the nurses or senior carers would sign the records. Care workers reported some nurses would ask if creams had been applied, but most didn't.  This meant some nurses were signing records without being sure if the products had been used.

Records for the application and use of topical medicines (creams and other external products) were incomplete and unclear. This meant we were unable to tell where and when they were to be used, who had used them and whether or not they had been used as prescribed.

We found medicine administration records were incomplete and inaccurate. There were missing signatures on records and it was unclear if medicines had been given or not at those times, for example one person's morning medicines had not been signed for four days within the last week. We checked the stocks of a sample of medicines against records and found at least four people had not been given their night medicines on 27 August 2016. A further three people had more stock left than expected, meaning that records had been signed without the medicine being given. We found three people had not been given their medicines as stocks had run out and further supplies had not been obtained in good time. This meant people did not always get their medicines as prescribed or in a way that met their individual needs and preferences

Most medicines were stored securely, with only authorised staff having access to the keys. The storage areas were clean and tidy and medicines were kept at the correct temperatures. We saw waste medicines, including some controlled drugs (strong medicines with additional storage and recording requirements) had not been disposed of and stored in line with current regulations and guidance.

Some people chose to look after some or all of their own medicines. We found risk assessments and care plans were not always in place and reviewed to ensure these people received the support they needed to take their medicines safely. One person told us that their inhaler had run out on a couple of occasions even though they had told staff when it was running low. This placed the person at risk of breathlessness. There were no checks in place to ensure that the person was using their inhaler correctly.

Many people were prescribed medicines, e.g. painkillers, that could be given at different doses or that only needed to be taken when required. We found there was not enough personalised information available to enable staff to use these medicines safely. It is important this information is available to ensure people are given their medicines safely, consistently and with regard to their individual needs and preferences. This is especially important when using agency staff that may be unfamiliar with the people who lived at the home, as well as when supporting people with communication difficulties or those living with dementia.

Although regular audits (checks) were completed, the system was ineffective as it had failed to identify any of the concerns and discrepancies that we found.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with people who lived at Morecambe Bay Care Home to ascertain their views on the staffing provision at the home. All the people we spoke with told us they received help quickly if they requested it. Comments we received included, "In answer to your question staff come promptly when they hear my bell. Waiting for help is unavoidable if there's an emergency of course but I don't usually wait." Also, "I've got a bell and if I press it staff come really quickly." And, "If I ring my bell they come to me quickly, I'm never worried about them not coming." One person described the staffing provision as, "improving now." However people who lived at the home told us they considered more staff were required. Without exception, all the people we spoke with told us staff were constantly busy. People told us they were able to have their needs and preferences met in a prompt way but described staff as 'busy.' Comments we received included, "Staff never stop working. They're a busy bunch." And, "I think they could do with more staff, they never stop." Also, "A few more staff would be handy because the girls look worn out some days." Relatives we spoke with voiced no concerns regarding the staffing provision at the home.

We spoke with staff and received mixed feedback on the staffing provision at the home. Two staff members told us they were concerned regarding the provision of staff at night. They told us they felt pressured to

respond to people's needs and preferences. We were told, "When we hear a buzzer we run." And, "We want to give quality care, the managers want us to give quality care but I don't think we can." Staff we spoke with told us the home tried to provide extra cover if unplanned leave was taken at short notice by staff, but this was not always possible. They said, "Management try, they really try but it's not always possible and we're short on permanent staff at the moment." A further staff member said, "We're a team and we do work together but some days I'm so tired because I won't let the residents down. I just keep going."

We discussed this feedback with the acting manager and the regional manager. We were informed they had attended the home during an episode of unplanned leave and had worked at the home to ensure people's needs were met. Both the acting manager and the regional manager told us they were committed to ensuring sufficient staff were provided. They explained the home used a dependency assessment tool. This is a formal tool which calculates the number of staff required to meet people's needs. Following our feedback the acting manager informed us they would review the assessment tool to ensure the calculation was correct. We were also informed they would aim to increase the staffing at night until this was completed.

The acting manager and the regional manager informed us the home was actively recruiting staff. We saw documentation which recorded staff were being recruited to ensure sufficient staff were available to support people. Staff we spoke with also confirmed they were aware additional staff were being sought. One staff member told us, "Management couldn't have done anything more to recruit staff." A further staff member said, "They're recruiting and I don't see what else management can do."

During the inspection we observed staff as they supported people. We saw staff were patient and kind and did not rush people. We spent time on each unit and timed six call bells. We observed staff responding to people quickly and calmly. We noted staff spent time with people. For example, we saw a staff member spent time talking with a person who chose to remain in their room. We further observed a staff member sitting with a person and talking about their family.

We reviewed rotas and records of staff hours worked. We saw occasions when staff were working in excess of their contracted hours. Staff we spoke with confirmed this was their choice. Staff told us they did this to cover shortfalls until new staff had been recruited. We discussed this with the acting manager. We asked if monitoring of staff shift patterns had been carried out. The acting manager spoke openly with us. They explained this had not been carried out in recent weeks due to the departure of the registered manager.

We noted the home employed agency staff if registered nurses were required to cover shortfalls. We discussed this with the acting manager. They acknowledged the home had a shortfall of permanent staff and existing staff were working extra hours. The acting manager told us they were planning to recommence systems in the home to monitor this. This would include 'return to work' interviews after sick leave had been taken and monitoring of the number of hours and shifts worked by staff. They told us whenever possible agency staff were booked in advance. They told us this helped to ensure continuity of staff for people who resided at Morecambe Bay Care Home. We spoke with three agency staff who confirmed this.

We recommend the registered provider seeks and implements best practice guidance in the monitoring and provision of staff for people with complex needs.

Requires Improvement

# Is the service well-led?

## Our findings

People who lived at Morecambe Bay Care Home spoke positively regarding the management of the home. Comments we received included, "The new manager is lovely and I get on with the deputy." And, "We've got staff and managers who are prepared to listen and change. It's great." Also, "I can't fault the new deputy or manager for that matter. They're great."

Staff we spoke with also made positive comments. We were told, "Management are friendly. We're a dedicated team. Everybody goes above and beyond." And, "You can go to any manager with anything and they'll try and change it." Also, "All the managers here are doing their best. It's a much better place to work." One staff member told us they did not feel included in any changes but had been assured by a member of management this would change.

As part of this inspection we reviewed management of medicines, staffing levels and maintenance of contemporaneous care records for people who lived at the home. Although regular audits of medicines were completed and a dependency tool used to determine staffing levels, the system was ineffective as it had failed to identify any of the concerns that we found.

We noted an area of improvement was required to the maintenance of contemporaneous care records. Documentation was not in place to inform staff of people's assessed needs. We reviewed five care records to ensure records were person centred and were reflective of people's needs and wishes. Three of the records we viewed did not contain sufficient information to enable staff to understand people's needs and wishes. For example, we saw a care record contained no instruction on how frequently a person should receive support to reposition to maintain their skin integrity. When we asked staff how often the person required support to change position we received conflicting information. We were informed by the registered nurse the person had no damage to their skin, however care records should be person centred and contain information to enable staff to deliver care in accordance with assessed needs. This is especially important when using agency staff that may be unfamiliar with the people who lived at the home, as well as when supporting people with communication difficulties or those living with dementia.

In a further record we saw a person had been identified as requiring extra fluids. There was no care plan in place to instruct staff on how this could be achieved and the amount of fluid the person required. The care record did not reflect the person's needs.

We visited one person in their room and saw they received food and fluids from a percutaneous endoscopic gastrostomy (PEG) tube. This is a method of supporting people to eat if they are unable to swallow or have breathing difficulties. In the person's room we saw information regarding the person's needs was in place from the hospital. We viewed the person's care record and saw no care plan or guidance was in place to instruct staff of the needs of the person. Staff we spoke with said they would consult the care plans if they needed information about the care and treatment people needed.

We discussed our concerns with the acting manager and on the second day of the inspection we saw

improvements had been made. We were informed the registered provider had provided additional support for the home and care records were being reviewed and a medicines audit completed. We reviewed the three care records we had identified as requiring improvement and saw care plans had been developed to ensure people's needs and wishes were documented.

We recommend the registered provider seeks and implements best practice guidance in relation to person centred care planning and documentation.

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010. Safe care and treatment.<br><br>People using the service were not fully protected against the risks associated with the administration, use and management of medicines. People did not always receive their medicines and creams at the times they needed them or in a safe way. Regulation 12 (1) (2) (g). |

**The enforcement action we took:**

Warning notice