Countess Mountbatten of Burma Romsey Memorial Trust

Edwina Mountbatten House

Inspection report

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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

About the service
Edwina Mountbatten House is a residential care home providing personal care to 16 people aged 65 and over at the time of the inspection. The care home can support up to 17 people, some of whom may have dementia. People are accommodated in one building, which is arranged over two floors and surrounds a courtyard. The registered provider is The Countess Mountbatten of Burma Memorial Trust, a registered charity run by a board of Trustees.

People's experience of using this service and what we found
There were areas where infection control practice needed to be improved to reduce the risk of infection and keep people safe.

Improvements were needed to ensure that the premises were fully secure and did not present risks to people. The provider has taken the required action to address these since the inspection.

Medicines were well managed overall, and people received their medicines as prescribed. We found some areas where medicine practice could be improved.

We were assured that there were enough staff to meet people's needs. Staff had been recruited safely.

People's relatives told us they felt confident that their family members were safe.

Staff knew residents well and provided support in an attentive and kind way.

We were not assured that systems in place to monitor the service, reduce risks to people and drive improvement were fully effective.

Records relating to people's care were not always accurate or up to date. This had not been identified by quality assurance systems.

We saw that the provider had invested in refurbishment to improve the décor of the building.

People and their relatives were able to give feedback about their care and this was acted upon.

People's relatives felt the service had kept them informed throughout the COVID-19 pandemic and spoke positively about the leadership team.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 30 April 2019). That inspection identified a continued breach of the Regulations regarding good governance. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found that although some improvements had been made, the provider was still in breach of regulations.

The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections. We will describe what we will do about the repeat requires improvement in the follow up section below.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 25 March 2019. A breach of legal requirements was found. The provider completed an action plan after the last inspection to show what they would do and by when to improve good governance.

We undertook this focused, short notice inspection on 29 January 2021 to check that the provider had followed their action plan and to confirm they now met legal requirements. The inspection was also based on the previous rating. This report only covers our findings in relation to the Key Questions Safe and Well-led.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection. Please see the Safe and Well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Edwina Mountbatten House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified breaches in relation to infection prevention and control and governance at this inspection.

Please see the action we have told the provider to take at the end of this full report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will

return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Edwina Mountbatten House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors.

Service and service type
Edwina Mountbatten House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we were mindful of the impact of the COVID-19 pandemic on services.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed information we had received about the service since the last inspection. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service. We reviewed a range of records, which included multiple medicines records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We sought feedback from eight relatives about their experience of the care provided. We spoke with eight members of staff including the registered manager, senior care workers, care workers, administrators and domestic staff. We reviewed nine people's care records. We looked at training data and quality assurance records. We sought feedback from two social care professionals who work with the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection

- There were some areas where infection control practice needed to be improved. Staff were not consistently following guidance which requires them to be bare below the elbow and not to be wearing watches and jewelled rings.
- Staff were not always disposing of personal protective equipment (PPE) appropriately. For example, we saw disposed PPE in open top overflowing bins in the entrance and communal dining area. We raised these concerns with the registered manager and received assurances that government guidance in relation to PPE is now being consistently followed.
- Care records showed that three people who had been admitted to the service or had returned from a hospital stay, had not been isolated in their rooms in line with government guidance. We raised our concerns with the registered manager, who was not aware that this guidance included people who had tested negative for Covid-19 prior to discharge from hospital.
- Further measures were needed to support social distancing. People were not socially distancing in communal areas such as the lounge and dining room. We recognised that the environment presented challenges due to the space available, however, we felt that opportunities for social distancing and shielding could be better maximised. We were not clear that potential mitigating measures had been fully explored with people and the circumstances sufficiently risk assessed.
- The registered manager had undertaken 'train the trainer' qualifications. They were responsible for providing staff training on 12 topics including infection prevention and control. However, we could not be assured the registered manager was aware of the latest guidance in relation to infection control to ensure that all training was in line with most recent best practice guidance.

We found no evidence that people had been harmed, however, people were placed at risk of harm due to best practice and government guidance in relation to infection prevention and control not being consistently followed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were assured that the provider had suitable measures in place to ensure that visiting was safe. The provider had made the service's hairdressing room available to visiting healthcare professionals, which they could access without entering the main entrance. A separate room was also provided for visitors to see their relatives, which could be accessed without entering the home. People's relatives were positive about how the service managed these visits. One relative told us, "I had previously been informed of the process by e-mail from the Manager… my temperature was checked, the questionnaire completed, I was then fitted with… PPE which was all disposable – rubber gloves, overshoe protectors, aprons and mask. I then sat one

side of a wide table with a Perspex screen divider."
● The environment was visibly clean during the inspection. The registered manager had introduced infection control duties to be shared across the team, such as disinfecting equipment or frequently touched areas. All staff spoke passionately about their role in preventing and controlling infection.
● The service had not had any outbreaks or cases of COVID-19. The infection prevention and control policy had been supplemented with a coronavirus policy and a contingency plan, which detailed how the service would manage any outbreak of infection. Staff had received infection control training.

Assessing risk, safety monitoring and management
● Improvements were needed to ensure that the premises were fully secure and did not present risks to people. For example, the laundry was not locked and could also be exited to an outdoor space, where waste was kept, and a bolted gate gave access to the road. A person had attempted to access the laundry. We also found a cleaning product and other items in a communal bathroom that could present a hazard to people if ingested. We discussed our concerns with the provider, who took immediate action to install a lock on the laundry door.
● It was unclear how risks were managed. For example, one person had lost a substantial amount of weight and it was not clear how this had been managed. Records did not provide assurances that this had been escalated and advice sought from health professionals.
● We were unclear about how the provider used food, fluid and bowel charts to monitor risks to people and ensure appropriate action was taken. We have asked the provider to review this to ensure they are an effective tool in helping staff review risks to people and monitor their health and well-being.
●People had care plans to guide staff on how to manage behaviours that might challenge. We noted that some care plans would benefit from being more detailed to support staff interventions. In the case of one person, it was not always clear that guidance within the care plan had been followed by staff. For example, care records did not show that staff used distraction techniques detailed within the care plan to support the person. Some staff also told us they would value further training in responding to behaviours which might challenge others.
● People's relatives told us they felt confident that their family member's health was well monitored and escalated to health professionals when required. One relative told us "The staff are very quick to identify when [person] is unwell and commence observations immediately. They notify [their] GP and/or 111 and always keep me informed."
● People had a range of risk assessments in place, for example, to help reduce the risk of falls. Nationally recognised tools were used to assess people's risk in relation to nutrition or skin damage.
● The provider had embedded the use of two tools endorsed by the NHS to help staff identify when people's health was deteriorating. Staff used these tools to assess people's well-being monthly or in the event of an accident or illness.

● A legionella risk assessment had been carried out in January 2019. The provider was planning to review and update the risk assessment following the unexpected installation of a new boiler in September 2020; however, this had not yet taken place. We were not provided with evidence of regular water sampling, which are tests carried out to determine whether levels of Legionella bacteria in the water are acceptable. We were not assured that the registered manager could assess whether the service was compliant with the Health and Safety Executives Approved Code of Practice (ACOPL8), as they had not received training. The provider has engaged a company to have oversight of the water system to ensure the system is safe, and people are protected from the harm the Legionella bacteria can cause.
● Records showed that staff had received fire training. Staff felt confident to respond to fire alarms, as they attended regular fire drills and the alarm was tested weekly.

● Monthly audits of the environment were carried out. Records showed that the provider commissioned contractors for maintenance tasks such as checking the safety of electrical equipment and servicing hoists, for example.
● Each person had a personal emergency evacuation plan (PEEP) detailing the assistance they would require leaving the building in the event of a fire.

Learning lessons when things go wrong
● Staff understood their responsibility to report incidents and accidents. Records showed that appropriate actions had been taken to escalate concerns to emergency services following a fall, for example. However, we also found that some of the subsequent investigations into incidents could be more probing and we were therefore not assured that all opportunities for learning had been maximised.

Using medicines safely
● Overall medicines were managed safely but there were some areas where improvements could be made.
● Topical cream administration records (TMARs) did not also provide enough information about where and how often the topical medicine needed to be applied.
● Protocols were in place for the use of 'as required' or 'PRN' oral medicines, however, staff responsible for administering medicines were not aware of these. We were concerned that this might impact upon people receiving their medicines in a responsive manner.
● Medicines administration records (MARs) did not consistently contain all of the required information. For example, four MARs did not include the person's photograph to ensure the medicine was given to the right person.
● People's relatives told us they were confident that the service managed their family members' medicines well. One relative said, "Of special mention is where a change of behaviour had been noticed with abuse to the staff. We had been informed and then later told that it had been traced to a change of medication that had led to addiction to a certain pain killer. [Person] was taken off that painkiller and things went back to normal. Totally impressed that the change of behaviour was fully investigated, diagnosed and solved – not just put down to old age."
● We reviewed 16 MARs and found no errors or unexplained gaps. We were therefore assured that people received their medicines as prescribed.
● There were effective systems in place for ordering and storing medicines, as well as returning unused medicines. Any liquid medicines were labelled with the date of opening the medicines and all medicines viewed were in date.
● Medicines were administered by staff who had received appropriate training. Staff told us that their competency was regularly reviewed by the leadership team.

Staffing and recruitment
●People's relatives were positive about staffing levels. One relative said, "When we visit, there always appears to be sufficient staff and we are always met with friendly greetings with politeness and respect."
● A dependency tool was used to inform planned staffing levels. A review of three weeks of rotas showed that planned staffing levels had been maintained.
● Staff told us there were enough staff available and staffing levels had recently been adjusted in response to a person's increased need for support.
● Two previous inspections had found that a full employment history had not been obtained for all staff employed. We were assured that a full employment history was now being obtained as part of the

recruitment process.

● Checks were carried out with the Disclosure and Barring Service (DBS) to ensure that a prospective member of staff had not previously been barred from working in adult social care or had a criminal record which meant they were not suitable for the post.

● Recruitment was based on an assessment of the candidates' skills and knowledge. One member of staff said, "It was very, very good, the manager and a senior asked every question imaginable, probably the most in-depth interview I'd ever had".

● Staff told us they had regular supervision and we saw detailed records of these meetings.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe at Edwina Mountbatten House. People's relatives spoke very positively about how the service kept their family members safe. One relative said, "They have got to know [person's name] well and we feel that [person's name] is well cared for and is kept safe".

● Staff had received safeguarding training and had access to safeguarding policies and guidance. Staff spoke passionately about their role in keeping people safe and were aware of the whistleblowing policy.

● People and relatives told us they felt confident about raising concerns with staff and felt these would be acted on.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

At our last inspection, the provider had failed to ensure that systems were fully effective at identifying areas where the safety and quality of the service was compromised. This was a continuing breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

● The leadership team now completed a wide range of audits which had the potential to support robust quality assurance. However, we found that the quality assurance systems in place still needed further improvement. They had not, for example, identified the areas of concern described elsewhere in this report. It was not always clear from the audits what evidence the registered manager was using to reach their assessments about the safety and effectiveness of the service.
● Information within care plans was not always consistent. For example, one person's care plan suggested that they were both unsteady and steady when walking. In some cases, care plans had not been updated when people's needs changed. For example, when people had experienced falls or lost weight. Staff knew people well and told us about the support they needed, which meant that people had not come to harm. We could not always see that guidance within the care plan was being followed by staff, however, this appeared to be because people no longer required the support indicated in their care plan. Improvements needed to be made to ensure that care records were accurate.
● There is a legal requirement for services registered with the Care Quality Commission to notify us of certain events such as serious injuries and deaths. We found that we had not been notified of two incidents.
●We found three incidents that met the criteria for a safeguarding referral but had not been reported to the local authority. This meant that not all opportunities for learning from the incidents had been utilised. We raised this with the registered manager who then made the relevant referrals.

We found no evidence that people had been harmed, however, systems in place to monitor the quality and safety of the service were not fully effective. This placed people at risk of harm and amounted to a continued

breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance.

● Daily handover meetings were held, so that important information could be shared with staff. Staff told us they were kept fully updated by the leadership team.
● The registered manager was supported by a head of care and senior care workers. Staff told us they had a good understanding of the management structure and described how they worked together as a team.
● The rating of the last inspection was on display at the service and on the provider's website.
● The registered manager told us they had received good support from the provider throughout the pandemic.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; and how the provider understands and acts on their duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● People's relatives spoke positively about the home's leadership team. One relative said, "In my opinion, [registered manager] is a superb leader – she is a very happy, positive person and this radiates through the team." Another relative told us, "We feel that the home is led extremely well by [registered manager] and her senior leadership team who are all very approachable and respectful."
● The registered manager told us that supporting people's choices and preferences was important to them. They spoke about how they had needed to balance keeping people safe, for example from the risk of infection, with promoting people's quality of life during the pandemic.
● We observed staff supporting people with a consistently calm and attentive approach. We also saw staff working well as a team. Staff told us that the pandemic had been challenging and had affected staff morale, but that they had supported each other. One member of staff said, "We all push each other, and we all know if anyone's having a bad day, so we keep up morale".
● People's relatives told us that staff quickly notified them of any incidents that involved their family members and kept them updated.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People's relatives told us that they had been kept informed throughout the pandemic. One relative said, "I have been invited to attend relative meetings and I am confident that my views will have been given every consideration".
● People were encouraged to provide feedback through residents' meetings, and this was acted upon. For example, people had been involved in discussing the menu and what activities they wanted to be arranged.
● Staff told us that they had regular staff meetings prior to the pandemic. We saw a letter from the registered manager to staff, which was sent monthly whilst meetings could not be carried out. Staff told us they were given opportunities to provide feedback and share messages with the team through this newsletter. One member of staff shared that they had been involved in making decisions about the new décor of the building to ensure that this positively impacted infection control and cleaning effectiveness.

Continuous learning and improving care
● The registered manager spoke passionately about developing the leadership team further. They had sought leadership training to develop the role of the head of care.
● Beyond mandatory training, the provider and registered manager had supported staff to undertake

further training such as the six steps programme for end of life care.

● We could see that investment had been undertaken to improve the décor of the premises, which had included refurbishment of rooms. The provider had implemented a care management system and there were plans for on-going improvements to the service.

Working in partnership with others

● The registered manager told us they were committed to working in partnership with other organisations. For example, the staff had been trained by the community health teams to carry out certain healthcare tasks during the pandemic.

● Records showed that staff had also worked with a range of professionals including GPs, physiotherapists, mental health nurses and the local authority to meet people's needs.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that best practice guidance in relation to infection prevent and control was consistently followed. This was a breach of Regulation 12 (1) (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor the quality and safety of the service were not fully effective. This was a continuing breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.