Ashberry Healthcare Limited

Moorhouse Nursing Home

Inspection report

Tilford Road
Hindhead
Surrey
GU26 6RA

Tel: 01428604381
Website: www.ashberry.net

Date of inspection visit:
12 August 2020

Date of publication:
30 November 2020

Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Moorhouse Nursing Home (Moorhouse) is a nursing home that provides care to older people, people with physical disabilities and complex medical needs. The home is registered to provide support to up to 38 people in one adapted building. There were 21 people living at the service at the time of our inspection.

People's experience of using this service and what we found
The provider had failed to ensure good management oversight of the service which had impacted on the care people received. There was a lack of monitoring and presence from the provider during the Covid-19 outbreak at the service which left people, staff and relatives at risk. Whilst people and staff told us they were reassured by the new manager they expressed disappointment at the support they had received from the provider.

Risks to people's safety were not accurately recorded and monitored. Where accidents and incidents occurred, staff did not consistently follow processes to reduce the risk of them happening again. Infection prevention and control measures had not been implemented in line with the government guidance during the height of Covid-19 pandemic. However, measures had now been implemented and were being embedded into practice by the new manager who started three weeks prior to our inspection.

The service had experienced significant staff shortages during the Covid-19 outbreak. As a result, a monitoring system had been implemented to determine the staffing levels required. This had led to improvements in how staff were deployed, so people were not waiting for their care. The new manager has continued to monitor this process to ensure this is embedded. We have made a recommendation in relation to this.

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 Require Improvement (28 February 2020) and there were multiple breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and sustained and the provider was still in breach of regulations.

Why we inspected
We undertook this targeted inspection to check on specific concerns we had about how risks to people were managed and the management oversight of the service. The overall rating for the service has not changed following this targeted inspection and remains requires improvement.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned

about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Moorhouse Nursing Home 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 identified breaches in relation to the provider's oversight of the service and the safety of people's care. Please see the action we have told the registered provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and the 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?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Moorhouse Nursing Home

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.

This was a targeted inspection to check on specific concerns we had about how risks to people's safety were managed and how the provider monitored the quality of the care people received.
As part of this inspection we looked at the infection control and prevention measures in place. This was conducted as part of our Thematic Review of infection control and prevention in care homes.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Moorhouse 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 did not have a manager registered with the Care Quality Commission (CQC). A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The manager at the time of the covid19 outbreak at the service was replaced by an interim manager in May 2020. A permanent manager who was familiar to the service had recently started their employment and planned to register with the CQC.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. This included safeguarding concerns and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. We sought feedback from professionals who work with the service. We spoke with four staff members and two people living at the service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service and two relatives about their experience of the care provided. We spoke with a further four staff members including the manager, nurses, care staff and housekeeping. We reviewed a range of records which included four people's care records, accident and incident monitoring and complaints records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We reviewed records including additional care monitoring charts for two people, quality monitoring, training records and policies and procedures. We spoke with the provider's quality and compliance manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check a specific concern we had about how risks to people's safety and well-being were assessed and managed. We will assess all of the key question at the next comprehensive inspection of the service.

Preventing and controlling infection

- Safe infection prevention and control measures had not been implemented to manage the risks of Covid-19 in a timely manner. This meant that at the start of the pandemic, the health of people and staff was put at risk.
- People, relatives and staff told us they had not been provided with guidance and up to date information they required during the initial outbreak of Covid-19 in the service. One person told us, "We didn't know what was happening. It was frightening at the time, but no one was saying anything. The staff were all worried."
- Staff told us they did not feel they had been supported to keep safe when the initial Covid-19 outbreak impacted on the service. A staff member told us, "We weren't given any information. We didn't have PPE (personal protective equipment) at the beginning and when we did get it, we didn't know how to use it. Everyone was ill and it was like they (management team) were pretending it wasn't happening."
- The provider told us they had been unaware the guidance they had shared with the previous manager was not being passed onto staff. The provider was unable to provide evidence of how they had tried to engage directly with staff, people or relatives to gain insight into how the service was managing the outbreak.
- Staff told us they were aware they should stay at home if they were displaying symptoms to minimise the risk of passing the virus to others. Despite this, some staff had come to work whilst feeling ill as they were informed by the previous manager they had a responsibility to do so. This instruction was against both the providers policy and national guidance.
- People and staff told us they had felt reassured when the interim manager and the new manager came to support the service. One person told us, "It's a lot better now (name) is here. Staff are wearing masks and everything. It feels much better." A staff member told us, "Once (interim manager) came in it started to get better. We have all the PPE now and we've had some training" Another staff member said, "The cleaning had gone downhill. It wasn't as it used to be but it's getting there now, and they've got all the proper Covid cleaning chemicals now."
- During our inspection we found safe infection control processes were being implemented. The service was clean and staff had access to sufficient PPE. Systems were in place to take the temperatures of people, staff and visitors and Covid-19 testing was completed regularly for people and staff.
- The new manager had started to complete Covid-19 risk assessments with staff and revised cleaning schedules to incorporate additional cleaning tasks. We saw evidence these processes were starting to be implemented.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

● Risks management records did not always contain sufficient detail to enable staff to monitor risks to people's safety and well-being. One person had experienced a high number of falls. Whilst staff were aware of this, the guidance within the persons care records did not describe how this risk should be minimised. There were no electronic monitoring devices in place to alert staff if the person stood up so they could offer prompt assistance. The manager told us this was being looked into.

● People's well-being was not always monitored following falls. This meant there was a risk signs of pain or ill-health might have not been identified and responded to promptly. The manager told us this should happen consistently and confirmed staff had been reminded of the need to complete well-being monitoring following a fall. Due to the short time they had been in post this process had not yet been embedded into practice.

● Risks to people's skin integrity were not always assessed and monitored effectively. Care records did not include clear guidance for staff on how to protect people. The manager told us they expected people who required regular changes of their position to prevent skin damage to be supported every two to four hours. However, this was not stated in the records of one person who was at risk of skin breakdown. The forms used to record when people were repositioned only gave an approximate time the person had been supported which meant this could not be accurately monitored. On one occasion a person's records contained no information to demonstrate they had been supported with repositioning for between six and eight hours.

● Concerns regarding people's skin integrity were not always acted upon promptly. Records for one person had alerted nursing staff to a pressure area. However, this was not reported to the person's GP until five days later.

● Accidents and incidents were not always reviewed to minimise the risk of them happening again. Of the 19 falls experienced by people in June, only two post-fall review forms had been completed. The actions required following the fall were identified, but not consistently completed. No regular audit of accidents and incidents had been completed in order to look for trends or repeated risks. This concern was also identified during our inspection in December 2020. This demonstrated the provider had failed to act on previous findings.

● We spoke to the manager about this concern. They informed us they were aware the processes were not being followed by staff and assured us this was in the process of being addressed.

The failure to ensure infection control processes and risks to people's safety were consistently and effectively managed was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing

At our last inspections in November 2018 and December 2019 we found the provider had failed to ensure sufficient staff were deployed to keep people safe. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that although improvements had been made, systems had not always been effective in ensuring consistent staffing levels were in place. We made a recommendation in relation to this.

● People told us staffing levels had improved since the new manager had been in post. One person told us, "I feel better about it now (new manager) is here. Staff seem much happier. They don't seem to rush as much." Another person told us the staffing situation had improved although there had been times of staff shortages due to sickness.

● During our inspection we observed sufficient staffing levels were in place to respond to people's needs promptly. Staff did not appear rushed and took the time to speak with people.
● Staff confirmed the number of staff deployed on each shift was more stable. However, they told us there had been extreme staff shortages during an outbreak of Covid-19 in April 2020 which had led to delays in people receiving their care. One staff member told us, "It was a very bad time. Staff were sick and there was no one to cover. We weren't allowed to get any agency staff. So many people were poorly which made it harder."
● The provider told us they had not always been aware of the staffing shortages later reported by staff and believed this was due to a lack of communication from the previous manager. Once an interim management team were in place, they ensured people's needs were reassessed to determine the correct staffing levels required. The new manager told us they were continuing this process.

We recommend that robust systems are implemented to enable the provider to assure themselves sufficient staff are consistently available to meet people's needs.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check specific concerns we had about the leadership and management oversight of the service. We will assess all of the key question at the next comprehensive inspection of the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspections in March and November 2018 and December 2019 we found quality assurance systems were not always effective and there was lack of management oversight of the service.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had failed to ensure consistent and robust oversight of the service. This had led to risks not being effectively managed and to a breakdown in communication between staff and the provider.
● When asked about communication with the provider, all staff members we spoke with told us they did not feel supported and did not believe their work during the Covid-19 outbreak had been acknowledged. One staff member told us, "It's disappointing that we don't hear from them. Just a card or an email to say thank you or check we're okay. I don't think they have any idea what it was like here or what we've been through. They were nowhere to be seen. We didn't feel we had anyone to turn to."
● Staff described the difficulties they had experienced during an outbreak of Covid-19 at the service. They told us of shortages of PPE, a lack of training and guidance, times of extreme staff shortages and high levels of anxiety. Staff expressed the previous manager did not acknowledge the situation and left them fearful of reprisals should they report their concerns. Staff informed us the provider made no contact with them during this time despite them being aware staff felt the manager at the time was unapproachable.
● Known concerns regarding the management of the service were not addressed or monitored by the provider. Following our inspection in December 2019 we had contacted the provider to feedback concerns from people, relatives and staff regarding the approach of the manager of the service at this time. The provider gave assurances they would address the concerns raised. Despite these assurances the nominated individual was unable to tell us what action had been taken. They told us, "I was told (by the provider) Moorhouse was 'in good hands' so I focused my time on (other) homes."
● The provider had not implemented effective systems to ensure staff felt able to speak out and ask for help during the pandemic. We asked the nominated individual what measures they had taken to promote an

open dialogue with staff and ensure they were aware of the whistleblowing policy. They told us, "I wouldn't be able to tell you if the whistleblowing policy was on a notice board. We haven't promoted it since the issues with (previous manager). I've walked around the home and spoken to staff and told them I'm in a room and they are welcome to come and speak to me. I even sat in the activity lounge for a bit." They told us two staff members had come to speak with them.

● We asked the nominated individual how they had sought to engage with staff during the pandemic as they were aware of these concerns. They told us, "All staff had my email address and number so they could contact me if they wanted." This demonstrated the provider had not taken proactive steps to support staff and to gain their feedback on how the service was being managed during the crisis.
● There was a lack of transparent communication with people and relatives regarding the Covid-19 outbreak at Moorhouse. A letter sent from the provider to relatives stated that with the exception of one person employed at the service, no people or staff were showing symptoms. However, at this time six people were showing symptoms along with a number of staff members. Two people living at Moorhouse told us they had not received any communication from the provider during the outbreak.
● Systems for reviewing the care people were receiving during the outbreak had not been effectively implemented. The nominated individual told us managers from all the provider's services had been requested to complete a Covid-19 audit. We asked to see copies of the audits returned from Moorhouse. The nominated individual told us they had not received any of these from Moorhouse and had not questioned why they had not been returned.
● There was a lack of quality monitoring systems in place during the Covid-19 outbreak at Moorhouse. The nominated individual told us they had conducted weekly calls with managers from all services in order to share experiences and guidance. Whilst managers from other services provided statements to say they had found these calls useful, this form of monitoring was not effective in ensuring people received safe care at Moorhouse. No other quality checks had been completed by the provider during this time.

The failure to ensure robust management oversight and continuous improvement was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The new manager had been in post for three weeks prior to our inspection. People and staff told us they were reassured by their approach and felt the manager had already made a positive impact. One staff member told us, "We have someone to rely on now."
● The provider has recently employed a quality manager to support all of the services. The quality manager described the systems they were implementing to support services in monitoring the care people receive. We will review the impact of these changes at our next inspection.
● The new manager employed at Moorhouse had a clear vision for the service and the improvements they wished to make. They had begun to review care records and were supporting staff to complete training.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure infection control processes and risks to people's safety were consistently and effectively managed

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	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had failed to ensure robust management oversight and continuous improvement

The enforcement action we took:

We issued a Warning Notice