Milestones Trust

Mortimer 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
Mortimer House is a residential care home providing personal and nursing care to 28 people aged 65 and over. At the time of the inspection there were 21 people at the home. Mortimer House accommodates people across two separate floors of the home. Each of which has separate adapted facilities. One of the floors specialises in providing care to people living with dementia and a learning disability.

People's experience of using this service and what we found

Before our visit a safeguarding allegation had been reported internally by a member of staff. This had not been addressed. This was then reported to a Commissioner for the service who was visiting the home. This led to a second serious safeguarding allegation being made about the same staff member. This also led to allegations that there were not enough staff at the home to meet safely meet people's needs.

People were not always supported to be safe. This was seen during our visit when a staff meeting took place. Every permanent member of staff went to the meeting. This left agency staff to support people. The agency staff were caring and worked hard to support people. However, at one point one agency staff member needed support with the needs of a person. They asked another agency staff member. This left one lounge with people in it unsupervised for several minutes. This in turn could have put those people at risk.

The service was not always safe in other ways. For example, it had been identified that staff handover meetings did not take place at 1pm when a number of staff came on duty. The service was not always safe as no actions had been taken to address this by management. It had also not been formally picked up that four new staff had not had a full staff induction programme.

Staff were kind and caring. They supported people with their needs promptly. People told us they felt happy living at the home.

The provider had taken clear action after a serious allegation of abuse was made to a visiting social care professional. They had seconded a very experienced registered manager and other staff from another of their services. These staff were working at the home to support the service.

We have identified a breach in relation to a lack of staff training and induction for new staff at this inspection. We also found a continued breach of the regulations around good governance.

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

Rating at last inspection.
The last rating for this service was Require Improvement when the service was inspected in September 2018. The service remains rated as requires improvement. The service has been rated requires improvement for

the last four consecutive occasions.

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

Why we inspected

We received concerns in relation to the safety of people at the home. Specifically, a significant allegation of abuse had been made about a staff member. This had not been swiftly and robustly addressed by the service. As a result, we undertook a focussed inspection to review the Key Questions of Safe and Well Led only.

We reviewed the information we held about the service. No areas of concern were identified in the other Key Questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection. The inspection was prompted in part due to concerns received about the safety of people after a recent concern was raised with us via the Local Authority. This concern led us to believe people's safety could be at risk. A decision was made for us to inspect and examine those risks.

We found evidence that the provider needs to make improvements. Please see the Safe and Well Led key question sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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

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

Follow up

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 also meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress.

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.

Mortimer 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.

Inspection team
The inspection was carried out by one Inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our Expert by Experience had direct experience of care home for people with a learning disability.

Service and service type
Mortimer House is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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
This inspection was unannounced.

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 reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

During the inspection-

We spoke with five people who used the service and one relative about their experience of the care provided.

We spoke with nine members of staff including the registered manager, a registered manager from another service who was supporting them, an agency nurse, a team leader and support workers.

We reviewed a range of records relating to the safety and management of the service, including policies and procedures and audits.

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 in September 2018 this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. 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.

Systems and processes to safeguard people from the risk of abuse

●Before our visit a safeguarding allegation had been reported internally by a member of staff. This had not been addressed. This was then reported to a Commissioner for the service who was visiting the home. This led to a second serious safeguarding allegation being made about the same staff member. This also led to allegations that there was not enough staff at the home to meet safely meet people's needs. We found that actions were being taken to address these allegations. Also the staff member concerned no longer worked at the home.

● People felt safe at the home. One person said, "I tell them what I want, and what I want to do, I like my bedroom, I don't sleep much at night, the people pop in to see me when it is dark". Further comments people made included "My family take care of everything for me" and "I have a very clear and detailed care plan, everything is written down, myself and my family have been asked to look at it and agree to what they have written."

● The home had a policy and safeguarding procedure. These were to guide staff if they became aware of abuse or had concerns. Since the last inspection, a member of staff had spoken to a visiting professional about concerns they had. They had followed the service safeguarding procedure, however they felt initially action had not been taken. This was now being addressed by the provider and the local authority. This was as a part of both an internal and external investigation.

Assessing risk, safety monitoring and management

● At 1pm the afternoon staff came on duty. We saw that there was no handover between the morning staff and the new staff. This meant people could be at risk. This was because staff would be supporting people unaware if there were any changes to their current needs. This in turn could lead to people receiving unsafe care and support.

Staffing and recruitment

●Staff were not always deployed in a way that was fully safe. On the day of our inspection, a staff team meeting took place. Every single member of the permanent staff team went into the meeting. This was held in the upstairs dining room. Agency staff were left supporting people with their needs. At one point an agency staff member asked another agency staff member for support. This was to assist them with a person whose behaviour may challenge others. This left a lounge unsupervised for several minutes. The lounge was occupied by several people. The registered manager told us the expectation for people's safety and wellbeing was that the lounges were always supervised.

● People felt there was enough staff to keep them safe. One person said, "Seems to be a lot of people around here to look after me, I am happy here". Another comment a person made was "Seems to be plenty of people around here to look after me, I like to go out, they take me". Further feedback was "I think plenty of people work here, I don't know who they are, different people all of the time". Another person told us "I don't know where my buzzer is in my room, it would be useful to know, sometimes I cannot pull my own trousers up and I have to shout for someone to come to me and help me." This comment was passed to the registered manager during our visit for them to act on.
● A relative told us, "There does seem to be a lot of different staff here, always changing faces, my relative does not really have to wait for attention, but at busy times, the staff seem stressed and don't know who to attend to first."
We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment must be provided in a safe way for service users.

Using medicines safely
●At our last inspection we had found some areas of medicine management that needed possible further improvement. This included dating topical creams when opened and checking pain relief patched on a regular basis to ensure they remain in the correct position on a person's body. These practices had now been addressed. People now received safe support with medicines. Medicines were stored safely in a locked room, so they were only accessible to people authorised to do so.
●Regular checks were completed and these picked up any matters that needed action and any errors.
● Systems were now in place to return unused medicines to the pharmacy. This was recorded in a book to ensure the risk of medicines being misused was minimised.

Preventing and controlling infection
● Staff followed safe infection control practices when supporting people with their care.
● There was also guidance in place to ensure staff knew how to prevent and control infection.

Learning lessons when things go wrong
● To learn lessons when things went wrong accidents and incidents were recorded reviewed and monitored. Information was recorded about the incident including who was involved and where it happened. This was analysed to look for trends.

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 in September 2018 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.

Continuous learning and improving care

●The audits completed by the manager since the last inspection in September 2018 were not fully effective. This was evidenced because the concerns found during the inspection had not all been acted upon. For example, the lack of staff induction, and the lack of a lunchtime handover had not been addressed. The registered manager and manager supporting them were aware that there was no handover when staff came on duty at 1 pm. After our visit we were contacted by the registered manager. They told us they had now put in place a staff handover at lunchtime for staff coming on duty.

This was a continued breach of Regulation 17 around Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Some staff told us there has been a lack of structure. This in turn had led to a lack of clarity around how to provide the best care and support to people. This was being addressed by the registered manager and manager who was supporting them. This was by improving communication methods with more regular staff meetings. It was also being addressed by giving all staff a copy of their most up to date job descriptions and making sure they understood it.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● People and a relative said they were kept informed about changes or issues about the service and their family member. People were also involved in care reviews and decisions made about care. People said they had good relationships with staff and the management team.

● The registered manager was clear about their responsibilities for reporting to the CQC and the regulatory requirements of their role.

● Complaints, accidents, incidents were recorded to look for themes.

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

● The registered manager and the manager supporting them also told us staff have not always been aware of job roles. This was being addressed by regular staff meetings as well as staff being reissued with their job

descriptions.

● The registered manager had put in place a new induction pack for all staff. However, four new staff had not done the staff induction programme. They had completed moving and handling training but had not yet done any other training relevant to their roles .

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

●People told us they felt engaged by staff. One person said "We have some meetings here, to say what is going on, and what is going to change. Another person told us "The staff are always asking if I am okay?" A third person said "I have been here for just over a month, not had any meetings that I have been to. I would describe this place as a nice place to live, with lots of people around, sometimes I am worried about not fitting in but so far everything seems alright."

●A relative told us "I came to a meeting last week, they did ask for our opinions on things; my family had a lot to say". They went on to add "I would describe this house as a lovely relaxed place for my relative to live".

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 Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality checking systems were still not fully effective.