Morven Healthcare Limited

Morven House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Morven House is a residential care home providing personal care to 29 people aged 65 and over at the time of the inspection. The service can support up to 40 people.

People's experience of using this service and what we found
People told us they did not feel safe at the service and we could not be assured that people were protected from the risk of abuse. There were insufficient staff on duty to meet people's needs and this impacted on the quality of service people received. People were not protected from risks to their health and safety and a clean, hygienic environment was not provided. Comprehensive risk assessments were not in place and people were not protected from all environmental risks. People were not protected from the risk of infection and were not adequately supported to maintain good personal hygiene. The staff were not consistently following current government guidance regarding protecting people from the COVID-19 virus. Safe medicines management practices were not being followed.

People's needs had not been adequately assessed to enable staff to provide the level of care and support they required. We could not be assured that people had timely access to other healthcare professionals to ensure all of their needs were being met. People's dignity was not always maintained and people were not always treated with respect. Staff were not up to date with their mandatory training and staff were not being adequately supported through regular supervision. An appropriate, well maintained environment was not provided.

There were ineffective systems in place to review and improve the quality of the service. Audits were undertaken but these had not been completed correctly and in the manner they were intended. They had not identified the concerns we found during inspection and were not being used to ensure the service was provided in line with best practice guidance. There were not appropriate systems in place to ensure peoples, relatives and staff views and opinions were gathered and used to ensure continuous improvement of service delivery. There was a lack of clarity of staff's roles and responsibilities, and who took accountability for certain aspects of service delivery. This was causing tension within the staff team and there was not a cohesive team approach to service delivery, impacting on the outcomes people experienced.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. People did have access to a balanced diet which met their nutritional needs and any specific dietary requirements. People were able to get support from their GP and the district nursing service.

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 good (report published 31 January 2020)

Why we inspected
We received concerns in relation to staffing levels and the management of the service. As a result, we undertook a focused inspection to review the key questions of safe, effective 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 overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe, effective and well-led 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 Morven 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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to person-centred care, safe care and treatment, dignity and respect, safeguarding, premises, good governance and staffing at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider to discuss how they will make changes to ensure they improve their rating to at least good. 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 with 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-Led findings below.	**Requires Improvement**

Morven 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 undertaken by two inspectors 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.

Service and service type
Morven 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. Morven House does not provide nursing care.

The manager was in the process of registering with the Care Quality Commission. This means that they, together with the provider, will be 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
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. 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 used all of this information to plan our inspection.

During the inspection:
We spoke with six people, nine relatives and eight staff (including the manager, the business manager, the administration, the senior care worker, two care workers, the chef and domestic assistant). We reviewed five people's care records, medicines management processes, staffing records and records relating to the management of the service. We undertook general observations throughout the day. We also spoke with the district nurse who was visiting on the day of inspection.

After the inspection:
We continued to seek clarification from the provider to validate evidence found.

Inadequate

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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- There were insufficient staff on duty to meet people's needs.
- The provider used a staffing dependency tool to calculate the number of staff required on shift. However, we saw that this had not been updated and at the last time this was calculated staffing levels were lower than the tool recommended, and staffing levels had remined low. We were told staffing levels were based on the number of people at the service, rather than their needs and the level of support they required.
- We heard from staff that they did not have the time to undertake all their duties and this meant at times they were not able to fully adhere to people's personal care or spend quality time with people to help manage their behaviours and anxieties. They also felt the risk of people falling or needing assistance in their rooms were not able to be appropriately managed because there were insufficient staff to support people safely throughout the building. Relatives also told us they felt there were not sufficient levels of staff at the service and this impacted on people's experiences, including people feeling like they had to stay in the communal lounge because there were not sufficient staff to supervise and support people in their rooms, not having staff to accompany them to hospital, and relatives having to meet some care needs because staff did not have the time to do it.

The provider was in breach of regulation 18 (staffing) of the HSCA 2008 (regulated activities) regulations 2014.

- Safe recruitment practices were in place. This included obtaining references from previous employers, checking staff's eligibility to work in the UK and undertaking criminal record checks.

Assessing risk, safety monitoring and management

- Risks to people's safety were not appropriately assessed or managed, and comprehensive risk assessments were not included in people's care records.
- One person with a history of falls did not have a falls risk assessment in place or any instruction to staff about how to reduce the risk of falls for that person. Another person's care plan did not include sufficient detail about how to care for their needs to ensure their health and safety and reduce the risk of infection associated with colostomy care. We also saw care records lacked information about diabetes care and how to support people safely with their diabetes.
- There was a high level of agency staff within the care team and they told us they had not always read people's care records. There was a risk that staff did not have all the appropriate information to support people with their needs and maintain their safety.
- Environmental risks had not been consistently identified and addressed, including the risk of falling from height from the balconies in place at the service which were in people's bedrooms in the newer part of the

building. Following our inspection an assessment of risk was undertaken for the balconies but the actions to mitigate the risk of people falling from height had not been completed.

The provider was in breach of regulation 12 (safe care and treatment) of the HSCA 2008 (regulated activities) regulations 2014.

Using medicines safely

● Safe medicines practices were not followed. From checking stocks of medicines and speaking with staff we were assured that people received their medicines as prescribed. However, we saw the medicines administration records (MAR), including the records for controlled medicines, were not signed at the time of administration. There is a risk that people may receive additional doses of their medicines because it had not been recorded on the MAR that their medicines had already been administered.

● We also saw in one person's care records that they wore a medicated patch but there was no information about why this patch was worn or where it was to be placed, leaving the person at risk of not receiving this medicine correctly.

The provider was in breach of regulation 12 (safe care and treatment) of the HSCA 2008 (regulated activities) regulations 2014.

● Medicines were stored securely and there were processes in place for the ordering, processing and disposal of medicines.

Preventing and controlling infection

● People were not protected from the risk of infection or adequately supported to maintain their personal hygiene. We observed people had dirty nails and one relative told us they had to, "Top up [their family member's] personal care" and "Visiting her after [the pandemic] was distressing, she was sleepy with dirty fingernails."

● A clean and hygienic environment was not provided. Some people's bedrooms had a strong malodour of urine and some bedrooms has brown stains on the walls. Some furniture was dirty and other furniture was so worn it could no longer be cleaned.

● We were not assured that the provider was admitting people safely to the service. The provider was not adhering to the government guidance in place at the time of inspection in regard to isolating new admissions to the service to reduce the risk of the other people using the service catching the COVID-19 virus.

● We were not assured that the provider was using Personal Protective Equipment (PPE) effectively and safely. Whilst staff were aware of what PPE to use and there were stocks of PPE available, we observed some staff during the inspection not wearing their face masks appropriately and securely. At times staff's masks where not covering both their nose and mouth.

● We were not assured the provider was facilitating visits for people living in the home in accordance with the current guidance. There were limited visiting opportunities at the service and people were not able to regularly have visits from their family. One relative told us, "We are limited to one visit every two weeks". Other relatives told us they had not been able to visit the home since the COVID-19 pandemic began.

● We were not assured the provider was sufficiently protecting staff at higher risk of becoming seriously ill from the COVID-19 virus. Risk assessments and mitigation plans were not in place to support staff at higher risk from the virus.

The provider was in breach of regulation 12 (safe care and treatment) of the HSCA 2008 (regulated activities) regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● We could not be assured that people were protected from the risk of abuse. One person told us, "I don't feel safe here". Another person said, "There's a lot of intimidation from the other people that live here."

● One staff member told us, "I don't believe [person using the service] unless it is fact and I see it…She's been diagnosed with dementia...In general, you should not trust what she says." There was a risk that people's concerns and experiences may not be taken seriously by staff because of their diagnoses putting people at risk of abuse.

● A whistleblowing policy was in place, but staff told us they felt unable to express their views and effectively whistle blow about concerns at the service without it impacting on job security. There were concerns there were not effective systems in place to raise concerns and safeguard people from the risk of abuse.

The provider was in breach of regulation 13 (safeguarding service users from abuse and improper treatment) of the HSCA 2008 (regulated activities) regulations 2014.

Learning lessons when things go wrong

● Staff were aware of reporting procedures when there were incidents or accidents. A reporting system was in place which meant all incidents were reviewed by the manager and there was monthly analysis of the types of incidents that occurred to identify any themes or trends. However, we saw that this analysis was not always included in people's care records. We saw in one person's care records that it commented on an incident that occurred but did not include any learning for mitigation of this behaviour potentially recurring or how it should be managed.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Adapting service, design, decoration to meet people's needs

- An appropriate, well maintained environment that met people's needs was not provided.
- Some of the bedrooms had water damage and damp. We also saw that one of the bathrooms was not in working order due to water damage leaving no bathroom facilities on one floor. The bath hoist was rusty. There were tiles missing on the walls of on one person's en-suite toilet. Curtains were ill-fitting.

The provider was in breach of regulation 15 (premises and equipment) of the HSCA 2008 (regulated activities) regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs assessments were not comprehensive and did not clearly outline their care and support needs. We reviewed care records for two new admissions to the service and these were lacking in information about the person, what support needs they had and how they wished to be supported. Full assessments had not been undertaken regarding people's mobility, falls, behaviour that may challenge or nutritional needs. There was a risk that people would not receive the support they required because there was a lack of information included in their care records and thorough assessments were not undertaken in line with best practice guidance.

The provider was in breach of regulation 9 (person-centred care) of the HSCA 2008 (regulated activities) regulations 2014.

- Whilst relatives told us they felt their family member was well looked after and one relative said staff, "Do genuinely care about [the person's] wellbeing", we observed that staff were not consistently ensuring people's dignity and treating them with respect.
- We observed female residents were not supported to wear bras or vests and observed one person lifting their jumper, which due to them not having any underwear on meant their bare skin was shown to the rest of the communal lounge impacting on their privacy and dignity.
- Some staff used inappropriate language when speaking about people including referring to people as "attention seekers" and describing one person as having "a personality like a child".
- Shortly after our inspection we were provided with evidence that people had not been able to access toilet roll impacting on their dignity and ability to maintain their personal care and appropriate hygiene standards.

The provider was in breach of regulation 10 (dignity and respect) of the HSCA 2008 (regulated activities) regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were not consistently supported to receive timely support with their health needs and access healthcare services.
● We observed people during our inspection having ill-fitting dentures, having long nails and one person told us they had not been provided with glasses with the correct prescription. Whilst we were told after the inspection that these issues had been addressed, there were concerns that people did not have timely access to dentists, chiropodists and opticians.

The provider was in breach of regulation 9 (person-centred care) of the HSCA 2008 (regulated activities) regulations 2014.

● The service worked well with their GP and the local district nursing service. We observed the district nurse visiting on the day of our inspection. They confirmed they reviewed all people with diabetes at the service who needed support with their insulin and staff identified people who may need additional nursing support, for example, with wound management.

Staff support: induction, training, skills and experience
● Some staff had not completed all of their mandatory training to ensure they had the knowledge, skills and competency to undertake their roles. This included completion of training on dignity and respect, positive behaviour support, and falls prevention training. One of the chefs had also not completed their food hygiene training.
● Staff had not received regular supervision and staff reported not feeling supported in their roles.

The provider was in breach of regulation 18 (staffing) of the HSCA 2008 (regulated activities) regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to maintain a balanced diet and have enough to eat and drink. One relative told us, "They keep an eye on what she's eating and keep a record of her weight."
● We observed food and drink being accessible throughout our inspection and during lunchtime most people ate their meals and told us they enjoyed the food.
● Staff were aware of people's dietary requirements and the chef prepared meals that met people's needs.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Staff were aware of who had a DoLS authorisation in place and the manager kept track of these. We saw they applied to the local authority when a person's DoLS needed reviewing or if they felt a person's needs had changed and they now needed a DoLS assessment to ensure their safety.
● Staff were aware of who had the capacity to consent to aspects of their care. Staff were respectful of people's decisions. For people who did not have the capacity to consent to aspects of their care, staff were aware of who had the legal authority to make those decisions on the person's behalf. There was one case where we felt further support could be provided to ensure a decision was in line with the person's best interest and advised the manager to seek support from the local authority which they have done.

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 good. At this inspection this key question has now deteriorated to requires improvement. 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; Continuous learning and improving care

- At the time of our inspection there was a lack of clarity of staff's roles and responsibilities, and who took accountability for different aspects of the service. This was causing tension within the staff team and there was not a cohesive team approach to service delivery.
- A quality assurance system was in place with a range of audits undertaken but these were ineffective and did not identify the concerns we found on inspection. The infection control audit, the health and safety audit, the dignity audit and the medicines audits did not identify the concerns we found, and one audit commented that the service "all looks and smells fine". Cleaning schedules had not been completed for the two days prior to our inspection. Many of the care records had not been audited for some time. We also identified that for many of the audits it was unclear when they were completed as there were two dates recorded on them, showing the audits were not being used in the manner they were intended and were not a comprehensive tool for reviewing the quality of service delivery.
- There was not a focus on continuous learning and improving care. The systems in place for reviewing quality had not been used as a means for continuous improvement and the staff were not following best practice guidance to ensure a high-quality service was provided.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff, people and their relatives were not engaged with in a meaningful manner to ensure their views and opinions were gathered and used to improve the service. Due to the COVID-19 pandemic there had not been a relatives' meeting in the last year. The service had also not sent any surveys or used any other methods to gather the views of relatives. There were infrequent meetings with people who used the service and we were unable to establish how these meetings were used to ensure continuous improvement of the service.
- Whilst there were staff meetings and some staff had received supervision, staff felt their views and opinions were not listened to. Staff felt they could not speak openly about their experiences and felt if they did it would have an impact on their job security.
- There was a poor staff culture at the service with very low morale. Staff were not working well as a team and did not feel supported by their managers. This was having an impact on the staff but also the quality of service delivery and the outcomes people experienced as outlined in the rest of this report.

The provider was in breach of regulation 17 (good governance) of the HSCA 2008 (regulated activities) regulations 2014.

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

- The manager was aware of the duty of candour and being open with people when things had gone wrong.
- The manager was aware of their responsibilities to notify the CQC of certain events that occurred at the service and statutory notifications were submitted in line with the provider's CQC registration responsibilities.

Working in partnership with others

- The service was working with other healthcare professionals, including the GP and district nurse team, to meet people's needs. However, as outlined in the key question effective we felt timely access to other healthcare professionals could be improved to ensure good outcomes for people.
- The service recently had contact with the local authority safeguarding team to review people's needs.
- Following this inspection additional support was being provided by the local authority's quality team and the manager confirmed they had already received support from the duty social worker in regard to particular concerns raised during inspection.

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 9 HSCA RA Regulations 2014 Person-centred care The provider was not carrying out an appropriate assessment of people's needs to ensure they received care and treatment which was appropriate, met their needs and reflected their preferences. Regulation 9 (1) (3) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured people were treated with dignity and respect. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from the risk of abuse and care and treatment was not provided in a way that was not discriminatory or possibly degrading to the people using the service. Regulation 13 (1) (4)

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 12 HSCA RA Regulations 2014 Safe care and treatment Safe care and treatment was not provided which appropriate assessed and mitigated risks to people's health and safety. Safe management of medicines was not provided and people were not protected from the risk of infections. Regulation 12 (1) (2) (a) (b) (d) (g) (h)

The enforcement action we took:

A warning notice was issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment A clean, suitable, well maintained environment was not provided. Regulation 15 (1)

The enforcement action we took:

A warning notice was issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not in place to effectively assess, monitor and improve the quality of service. Risks had not been appropriately mitigated and accurate, complete and contemporaneous care records had not been maintained. Feedback was not sought from relevant persons. Regulation 17 (1) (2) (a) (b) (c) (e)

The enforcement action we took:

A warning notice was issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient number of staff to meet people's needs. Staff had not been provided with adequate training and support to undertake their roles. Regulation 18 (1) (2) (a)

The enforcement action we took:

A warning notice was issued.