Hampton (Midland Care) Ltd

Midland Care Home

Inspection report

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13 July 2020

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Midland Care Home is a nursing home that is registered to provide care for up to 66 older people. There were 20 people living at the service at the time of the inspection, some of whom were living with dementia.

People's experience of using this service and what we found
Risks to people were not consistently mitigated, the provider and registered manager had not maintained effective oversight in this area. Lessons had not consistently been learnt when things went wrong.

Medicine administration was not consistently safe. Nursing competency checks were not regularly completed. Medicines were stored and disposed of safely.

We were not reassured of good infection control practice. Management oversight in this area required improvement.

The provider and management team were committed to improving the service and were working with other organisations and privately sourced support to drive improvement. However, professional partnership working was not always effective as professional advice was not consistently followed to mitigate risk.

Staff support and supervision was inconsistent.

The provider and management team were open and transparent with people and their relatives and reported incidents to the local authority and Care Quality Commission.

People were protected from the risk of abuse. Staff were recruited safely.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was Requires Improvement (published 11 December 2019). The service is now inadequate.

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

Why we inspected
We undertook this focused inspection to check if the provider had made improvements and if they were now meeting the legal requirements. This report only covers our findings in relation to the key questions

Safe and Well-Led.

We used the ratings from our last comprehensive inspection for the key questions not inspected this time to calculate the overall rating.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Midland Care 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 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 found breaches in relation to the safety and managerial oversight of the service at this inspection. Please see the action we have told the provider to take at the end of this report.

The overall rating for this service is inadequate and the service is therefore in special measures. This means we will keep the service under review and will re-inspect within six months of the date we published this report to check for significant improvements.

If the registered provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question, we will take action in line with our enforcement procedures. This usually means we will start processes that will prevent the provider from continuing to operate the service.

For adult social care services, the maximum time for being in special measures will usually be 12 months. If the service has shown improvements when we inspect it, and it is no longer rated inadequate for any of the five key questions, it will no longer be in special measures.

What happens next?
We will meet with the provider to discuss how they will make improvements. We will work with the local authority to monitor progress until we carry out our next inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Midland Care Home

Detailed findings

Background to this inspection

Service and service type
Midland Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and we looked at both during this inspection.

The service had a manager registered with the Care Quality Commission. Registered managers and providers have legal responsibilities for how they run the service and for the quality and safety of the care provided.

Inspection team
The inspection was carried out by two inspectors.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We contacted health and social care commissioners who have a responsibility to monitor the care of people. We used the information the provider sent us in the provider information return. This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with one person who used the service and seven relatives of people who used the service about their experience of the care provided. We spoke with eleven members of staff including the registered manager, deputy manager, a director, the clinical services manager and seven care workers.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at specialist diet receipts, managerial audits, records in relation to pain management and medication, meeting minutes and policies and procedures. We made telephone calls to relatives and staff on the 13 July 2020.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection we have rated this key question inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to have systems in place or systems that were robust enough to demonstrate safety was effectively managed. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, the provider had not made enough improvement and was still in breach of regulations.

Assessing and managing risks; Ensuring equipment and premises are safe. Using medicines safely. Preventing and controlling infection including the cleanliness of premises

- Risks to people were not consistently managed safely. For example, where people were identified as at risk of choking, they had been prescribed thickening powder or liquid to add to their drinks. Fluid records evidenced that staff were not consistently following instruction on the prescribed level of drink consistency. We discussed this with the provider who agreed to review this to ensure people's safety.
- One staff member confirmed that they did not consistently follow the prescribed level of drink consistency due to the persons preference but supervised the person to prevent choking. We did not see evidence of a rationale or clinical guidance around this practice in the records we looked at.
- The risk of malnutrition was assessed and planned into people's care. However, staff did not consistently follow the guidance and some people remained at risk of malnutrition. One staff member said, "I haven't read the care plans, we don't have time to read the care plans." Another staff member said, "Records were difficult to follow and keep on top of."
- Equipment was not consistently well maintained. One person had been using equipment with a faulty safety belt for six months. This was brought to the attention of the provider who agreed to ensure this was taken out of circulation immediately and repaired.
- Medicines were not consistently managed safely. Individualised PRN (as required) protocols to support the safe management of medicines were not readily available to clinical staff to support medicine administration. A staff member told us they had not been available for a few weeks. Some people did not have a PRN protocol for their medicines at all. This meant people were at risk of not receiving their medicine as prescribed.
- We observed people were not consistently given their medicine in line with current best practice guidance. One person was given a prescribed liquid food supplement to drink whilst laid down in their bed. They were supported with a few sips then given the bottle and the nurse left the room. We observed the person could not sit up unaided so was at potential risk of choking. We alerted the nurse who returned and supported the person to finish the supplement.
- We identified some people were refusing their medicines. Guidance was not available to staff on what action to take in this instance and medical guidance was not sought. This meant people were at risk of experiencing severe adverse effects such as a deterioration in their health as a result of missed medicines.

This was highlighted to the clinical services manager during the inspection, who sought GP guidance and implemented guidance for staff to follow.
● Staff did not ensure the correct use of personal protective equipment. Two members of staff were observed to not be wearing their surgical facemasks correctly as per current national guidance whilst supporting people with their care needs. This meant that people were not always protected from the spread of infection.
● Cleaning regimes were not consistently followed to ensure good infection control procedures took place. There was no recorded rationale as to why some cleaning had not taken place.
● Specific detailed schedules for increased cleaning during the Covid-19 pandemic had not been implemented. There was instruction for staff to clean "high touch" areas at each shift change, this had not consistently been completed. Records showed long periods between cleaning for some high touch areas.

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 continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Regular fire alarm checks took place and trained fire marshals were allocated daily to take charge in the unlikely event of a fire.
● The building was well maintained with risks to people considered. For example, window restrictors were fitted to prevent the risk of falls from height.
● Medicines were stored and disposed of safely.
● The home was visibly clean and odour free. Relatives told us when they were visiting pre-lockdown the home was clean and odour free.

Learning lessons when things go wrong
● Lessons had not consistently been learnt when things had gone wrong. Where audits had been carried out and a need for improvement identified this had not always been actioned.
● Two separate audits identified missing PRN protocols for people. This had not prompted a further review for all people receiving PRN medicines or for regular checks to be implemented. As a result, this remained an issue and people remained at risk of not receiving their medicines as prescribed.

Safeguarding people from the risk from abuse
● People were protected from the risk of abuse. Staff were trained and knowledgeable around types of abuse, signs to look out for and the need to speak out to protect people. Staff understood they could report abuse to the local authority and the Care Quality Commission as well as the registered manager and provider.
● Staff told us they had access to safeguarding and whistleblowing policies and procedures for guidance.
● Relatives told us they felt people were safe and protected.

Staffing; Recruitment
● Relatives told us they felt there were enough staff to meet people's needs and relatives we spoke with told us staff were kind caring. We received a mixed response from staff with some feeling there were enough staff but others disagreeing. One staff member told us that staff were going without breaks to ensure people's care needs were met. Another staff member said there were enough staff as the home was not at capacity.
● We identified that the providers dependency tool had calculated staffing ratios incorrectly according to people's current recorded needs. This meant we could not be sure the home was operating with enough staff to keep people safe. We discussed this with the deputy manager who agreed to review this with the

provider's consultant the following day to ensure there were enough staff to meet people's needs.

● Staff were recruited safely. The provider ensured that the professional register for qualified staff was checked prior to them commencing employment, with annual checks thereafter.

● Disclosure and Barring Service (DBS) checks were completed for all staff prior to them working with people. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

Inadequate

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 Requires Improvement. At this inspection this key question is now Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to have sufficient systems and processes to assess monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Managing the quality of the service, meeting legal requirements and staff and managers being clear about their responsibilities. Continuous learning, innovation and improving the quality of care. Engaging and involving people using the service, the public and staff. Working in partnership with others

- Systems and processes to monitor the safety and quality of the service were inconsistent, the governance structure was not sufficient in mitigating risk. Staff and managers were not always clear about their responsibilities.
- Trained clinical staff were responsible for checking care records daily but had not identified errors in record keeping or where care needs had not been met. This meant people had continued to receive care that had not consistently met their needs.
- The registered manager had implemented a system to monitor falls. However, records evidenced this system had not captured all the data required to ensure good oversight, therefore some people experiencing falls had not been included in the monitoring process. We identified with the deputy manager that staff had not consistently understood their responsibility to complete an accident and incident form.
- Unwitnessed falls in communal areas had been identified and recorded. However, the registered manager had not taken action to review staffing numbers or put measures in place to reduce the risk of recurrence. The registered manager and provider relied on limited information for post fall analysis.
- The providers dependency tool used to calculate enough staffing numbers showed incorrect figures, this had not been identified prior to the inspection. This meant the provider could not be sure there were enough staff to support people's needs.
- Infection control audits did not include checking cleaning records had been completed. Therefore, gaps in cleaning records had not been identified and we were not reassured of good infection control practices.
- 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 Mental Capacity Act (MCA). In care homes this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). There was no system, process or evidence in place to ensure that when people had conditions on their DoLS that these conditions were being met.

● Errors and missing information from mental capacity assessments had not been identified during audits. For example, we saw several people with stair gates and sensor mats still awaiting an MCA assessment. There was no clear rationale documented in peoples care records to say why these had been put in place.
● Where systems and processes had identified the need for improvement this had not consistently been actioned. For example, some audit actions remained outstanding, were overdue and missed the completion deadline.
● Staff supervisions and appraisals were inconsistent and not completed in line with the providers schedule. We received a mixed response from staff about the support they received from the management team, some staff felt listened to, supported and enjoyed their role. Other staff felt management support needed improvement and staff morale was low.
● Where the service had sought advice from healthcare professionals, records evidenced recommendations had not always been followed. For example, where dietitian advice had been sought and nutritional care plans implemented these had not consistently been followed by staff. This meant people remained at risk of malnutrition. This had remained unnoticed until highlighted during the inspection.
● People had personal emergency evacuation plans in place which staff knew where to find if needed. However, these had not been reviewed in line with the providers policy and procedure.

The provider failed to have systems in place to assess, monitor and improve the quality and safety of the services provided. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider had recently implemented an electronic medication system to streamline the process, prevent errors and improve clinical oversight. This was not yet embedded in practice at the time of the inspection and required further input of information to ensure nurses had all the information needed to support people.
● People were supported with accessing the community prior to the Covid-19 lockdown period. For example, one person had regularly attended a local community activity and there had been trips into the local town for shopping and social activity.

Acting with honesty and transparency if something goes wrong
● The registered manager had demonstrated transparency by reporting incidents to the local authority and CQC. The local authority had recently offered guidance on non-reportable incidents to support the registered manager.
● The service was meeting the requirements of the duty of candour. The duty of candour is a legal duty for providers to act openly and honestly, and to provide an apology if something goes wrong.
● Relatives told us they were informed promptly if something went wrong or if there were changes in people's health and social care needs. Relatives knew how to make a complaint and felt they would be listened to. The provider has a system in place to monitor complaints.

Leadership vision, values and culture
● Relatives spoke positively of the registered manager and provider and felt the service was working towards improving. Relatives told us the provider was kind, caring, supportive and actively involved in the home.
● The provider was committed to ensuring people's diverse and cultural needs were met and employed a work force that reflected the needs of people living in the home. For example, staff were able to converse in languages other than English to engage with people in their care. People had been supported to attend places of worship prior to the Covid-19 lockdown.

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 The provider had failed to have systems in place or systems that were robust enough to demonstrate safety was effectively managed.

The enforcement action we took:

We issued the provider with a warning notice and will return within a set time period to ensure provider compliance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to have systems in place or systems that were robust enough to demonstrate management oversight of the quality and safety of the service was effective.

The enforcement action we took:

We issued the provider with a warning notice and will return within a set time period to ensure provider compliance.