Moriah House Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Moriah House is a residential care home providing personal care to 49 people aged 65 and over at the time of the inspection, some of whom were living with dementia. The service can support up to 50 people in one adapted building over two floors.

People's experience of using this service and what we found
People were not kept safe from risks that could impact their physical wellbeing. Staff were not kept up to date with training to safely meet people's individual needs and protect them from the risk of abuse. People were supported to take their medicines safely.

There was ineffective systems in place to monitor the safety and quality of care being provided to people. People and staff felt they were not listened to by management. The provider did not ensure learning and improvement was taking place.

People were not always treated with dignity and respect. People were not being actively included in decisions about their care.

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 (published 19 February 2019).

Why we inspected
We received concerns in relation to the management of the service, safeguarding and training. As a result, we undertook a focused inspection to review the key questions of safe, caring and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.
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 inadequate. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvement. Please see the safe, caring and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Moriah 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 risk management, staffing, safeguarding, dignity and care, and management of the service 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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
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, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

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 caring?

Inadequate

The service was not always caring.

Details are in our caring findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Moriah House Limited

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out 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
Moriah House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

Notice of inspection
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. We used all of this information to plan our inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements

they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with eight people who used the service and eight relatives about their experience of the care provided. We spoke with 10 members of staff including the registered manager, deputy manager, senior care worker, care coordinator, care workers, members of the activities team and the kitchen assistant.

We reviewed a range of records. This included nine people's care records and multiple medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Following the day onsite we reviewed documents requested from the provider, including quality assurance records and rotas. We also contacted a further 18 members of staff, however only four spoke with us. We also sought feedback from healthcare professionals who have worked with the service.

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.

Systems and processes to safeguard people from the risk of abuse
- People were at risk from not being protected from the risk of abuse or harm.
- Systems and processes in place were not effective, internal investigations were not thorough which meant actions were not being identified to prevent potential reoccurrences of incidents.
- Staff had not all been trained in safeguarding, which meant they may not recognise or report potential occurrences of abuse.
- There was a safeguarding policy in place, however this did not contain a comprehensive procedure for staff or management to follow when there were safeguarding concerns.

The provider failed to ensure there were adequate processes in place to safeguard people from abuse. This is a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
- People's risks in relation to their health, care needs and environment were not being assessed, mitigated or managed effectively in order to keep people safe.
- People were at risk of scalding from hot water outlets. We found water temperatures had been recorded as scalding in some people's bedrooms for a number of months without any escalation or action taken to rectify these.
- People living with dementia were at risk from falling down an open stairwell. At the time of the inspection this risk had not been assessed or mitigated.
- Staff had not received training in key areas such as food hygiene, dementia, managing behaviours that may challenge, fire safety, medicine administration, health & safety and infection control. This meant they were not being kept up to date with skills required to meeting people's needs safely.
- People's vital information was not always available. For example, we found some people did not have personal plans for evacuating in an emergency. New admissions did not have plans or assessments in place and information about their dietary requirements was not shared with kitchen staff. This meant people were at risk of not being supported safely.

The provider failed to ensure people received care and treatment in a safe way and protect them from the risk of harm. This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staffing levels were not calculated in systematic way to ensure there were enough staff on each shift to meet people's needs.
● People told us they sometimes had to wait for staff to support them. A person said, "I keep asking them [staff] and they say they will be back in a minute but then they don't come".
● We observed people having to wait for staff to support them, for example people were being told by staff they must wait for the toilet as they were busy supporting other people. We also observed communal areas were left unattended for periods of time.
● Appropriate pre-employment checks were carried out to gain assurances about potential staff members suitability. However, records were not kept of interview questions asked or candidates responses.

The provider failed to have a systematic approach to determine the number of staff and range of skills required in order to meet the needs of people using the service and keep them safe at all times. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Systems and processes in place placed people at increased risk of infection.
● People were not being isolated in line with government guidance and best practice. The provider did not ensure risks associated with the failure to isolate were assessed or mitigated against. This placed all people living in the home at increased risk of transmission of an infection.
● People were not encouraged to social distance within the home, for example there were no staggered lunchtimes.
● Staff were observed not to be using PPE effectively or safely.
● We were not assured the provider was facilitating visits for people living in the home in accordance with the current guidance. Indoor visiting had not been offered to relatives. Relatives told us they were confused as to why they were unable to visit their relative indoors as they were willing to take tests and follow the guidance.

The provider failed to protect people from the risk of infection. This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● There were limited investigations into incidents and there was not a proactive approach to safety concerns. For example, falls were not analysed to take action to prevent reoccurrences.
● We observed a culture of blame within the service. For example, when concerns were raised by the inspection team, management tried to establish whose fault it was that it hadn't been done instead of trying to rectify it to promptly protect people.
● There was little evidence of learning from incidents. Staff told us little information was shared with them following incidents.

Using medicines safely
● Medicines were managed and administered safely.
● People told us they were supported to take their medicines and were able to get pain relief when required. They said, "Medication is usually on time if they are not busy, and you can get pain relief anytime you need it".

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

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 people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People were not always treated well or respectfully.
- People said, "It is horrible, and I know I moan a lot but you've not much else to do except sit here and wish you could go home. The staff think I am always moaning but if you are not happy you have to say something don't you", "They just plonk your breakfast down and get out as fast as they can. They don't come and chat or check I am Ok unless they are bringing something," and, "We just tend to sit about, and it is a bit boring at times. I have lost my spectacles and would read if I had them."
- A relative told us they were upset about how a member of staff spoke about their relative to them and how they felt staff had put their relative in isolation due to being disruptive. We observed staff speaking about people with a lack of respect and saw statements in peoples care plans using undignified language.
- We observed a lack of interaction from staff with people, and staff telling people they had to wait to use the toilet.

Supporting people to express their views and be involved in making decisions about their care

- People were not able to express their views and there was little evidence of people being supported to make decisions about their care.
- A person said, "We get our lunch around 12 and you get what they give you." Another said, "I have a list of things I can't eat, and they do tend to stick to the list. I tell them if they don't. Sometimes I send things back because I can't eat them, and I don't always get anything in replacement."
- People didn't feel involved in maintaining their own wellbeing. A person said, "No one discusses your health or anything, you are just here."
- Relatives told us they did not feel involved in making decisions about their loved ones care and had not been involved in care planning.

Respecting and promoting people's privacy, dignity and independence

- People were not always treated with dignity.
- A person told us how they were unhappy because they had not been supported with washing and only got a shower every 10 days, they described how they had to wear the same pyjamas all day every day.
- We observed a person becoming distressed as they were not given their own clothing. Relatives told us they had seen their loved ones wearing clothes which did not belong to them.
- In the bedrooms the windows were exposed and the bedroom toilets did not have closable doors, this placed people's privacy and dignity at risk.

The provider failed to ensure people were being supported in a caring, dignified and respectful way. This is a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 as requires improvement. At this inspection this key question has now deteriorated to 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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; Working in partnership with others

- The registered manager had not always assessed, monitored and improved the quality and safety of the care and treatment provided. Audits and quality monitoring processes were not completed consistently or effectively.
- Risks to people's safety were not always assessed, monitored or mitigated against. For example, risks around infection control and water temperatures. Incidents were not always reviewed by the management to ensure correct procedures were followed, including notifying relevant agencies such as CQC.
- Records were not always accurate, complete and contemporaneous in respect of each person.
- Relatives told us they did not feel informed about their loved ones physical and mental wellbeing. A relative explained, "I don't get any information about what is happening or how [person] is doing, no one talks to me." Another said, "I have to ring them, they never ring me…they don't tell me what [person] been doing. It's as if they want me off the phone as soon as they can."

The provider failed to ensure the service was being managed effectively to maintain the quality of care and safety of people. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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;

- People, staff and relatives were not engaged or involved in the service nor did they feel listened to. There was not a person-centred approach embedded in the service.
- People told us, "The manager doesn't come to talk to me. I tell them I haven't had any dinner and they [staff] just shrug it off," and "The manager is nice enough but when I see her and tell her things she thinks I am moaning so doesn't listen".
- Relatives said, "I haven't been asked about [relative] at all, not what [person] did, or what [person] likes or anything," and "No one has asked us anything about [relative] and their likes etc. Nothing has been discussed with me and to be honest I feel a bit out on a limb as I don't know what is going off." Another said, "I do question why we can't go into their rooms now like other homes are allowing. We got a letter to say we could increase visits from 1 to 3 times a week but still not inside. I would like to know why we can't go in".

● Staff said they would like were more staff meetings and a staff room. Care staff felt excluded, they explained, "The seniors don't tell us anything. We are all in it together there are lots of things that are held back, as if we aren't worthy of knowing anything."

The provider failed to ensure the service engaged and involved people. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

● The provider did not have systems to effectively learn and, in turn, improve care.
● Staff said, "We've never had management getting staff together to inform or share anything, we are just kept away" and "Management never update us on what we've put forward."
● There were resident meetings and quality surveys sent out to people and their relatives; however no action was taken from these to address concerns raised nor was feedback given to people.
● There was no evidence of learning from incidents or taking on board recommendations from other agencies, such as the local authority safeguarding team.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not always supported in a dignified or respectful way. The provider did not ensure people's rooms promoted dignity and privacy. Reg 10 (1) (2)

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 Staff were not all trained in safeguarding. Safeguarding systems and processes in place were not robust. Reg 13 (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not a systematic approach to determine the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times. Reg 18 (1)

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 Risks were not being assessed or monitored effectively. These included environmental risks and infection control risks. Staff did not have adequate training. Reg 12 (1) (2) (a) (b) (c) (h)

The enforcement action we took:

We issued a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure the service was being managed effectively to maintain the quality of care and safety of people. Regulation 17 (Good Governance).

The enforcement action we took:

We issued a Warning Notice