Welford Healthcare MC Ltd

Morris Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Morris Care Centre is a nursing home providing personal and nursing care to up to 96 people. The service provides support to older people, people living with dementia, people with physical disabilities, learning disabilities or autistic people and younger adults. At the time of our inspection there were 79 people using the service. The home was split into three separate units, each unit had kitchenettes and communal spaces.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

People's experience of using this service and what we found
Right Support:
People did not always receive their medicines safely or as they were prescribed. Staff recruitment and induction training processes promoted safety. Staff knew how to consider people's individual needs, wishes and goals.
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.

Right Care:
Health professionals provided mixed feedback about their directions not always being followed. People's mealtime experience required improvement so that people had an accurate menu. To choose from. People were not always treated with dignity and respect.

Right Culture:
The provider failed to ensure the governance systems in place were always effective in delivering high quality care and support. Appropriate incidents were being reported to the Care Quality Commission. The provider sought feedback from people and those important to them and used the feedback to develop the service. The principles of the duty of candour were being followed at the home.

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 requires improvement (published 6 May 2023) and there was a breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We undertook a targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about the safe administration of medicines, staffing levels and pressure care treatment. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with the administration of medicines, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe, effective, and well-led.

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.

Enforcement
We have identified breaches in relation to safe administration of medicines and the providers governance 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 from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 effective?

Requires Improvement

The service was not always effective.
Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.
Details are in our well led section below.

Morris Care Centre

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 Health and Social Care Act 2008.

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 3 inspectors on each day.

Service and service type
Morris Care Centre is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Morris Care Centre is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
The first day of the inspection was unannounced. We let the provider know when we would visit for the 2nd day of the inspection.

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, Healthwatch and professionals who work with the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 17 people living at Morris Care Centre and observed care and support being given in communal areas of the home. We spoke to 5 friends and relatives.
We spoke to 17 members of staff including the Nominated Individual, Head of Care Quality, Registered Manager, Deputy Manager, Nurses, Nursing assistants, Senior Care Assistants and Care Assistants. The nominated individual is responsible for supervising the management of the service on behalf of the provider.
We reviewed a wide range of records, such as care plans, medication administration records, staff records, quality assurance documents and policies and procedures.
After the inspection we received further information from the provider regarding the governance of the service and obtained feedback from 5 healthcare professionals that work with the service.

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 our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained 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.

Using medicines safely; assessing risk, safety monitoring and management
- The provider failed to ensure people received their medicines as prescribed and in a safe way.
- People could not be assured they would receive their medication as prescribed. We identified discrepancies between the actual and expected quantities of some medicines in stock. This indicated people may not have consistently received their medicines as prescribed.
- People could not be assured that their medication would be stored in accordance with the manufacturer's instructions.
- We found one person's insulin had not been dated when removed from the fridge. The insulin in use could only be safely kept out of the fridge for 28 days. This meant we could not be assured that the insulin was safe for use. The insulin was removed from use immediately when we raised these concerns.
- We found in 1 unit; staff were not carrying out daily checks on the temperature of the fridge where the medicines were stored. Records showed that these were completed sporadically. This meant medicines may have been stored unsafely which could affect the safety and effectiveness of medicines.
- One person had been prescribed a rescue medication for seizures which was stored in case it was needed. The medication had passed its expiry date and was no longer safe to be used. This placed the person at increased risk of harm should it be required to be administered.
- People could not be assured they would receive all their prescribed medicines. Systems had failed to identify that 1 person had a medicine wrongly entered on the electronic medication system in June 2023. Although prescribed to be administered daily, the medication administration record showed that it had not been administered in June 2023 and up to 7 July 2023 when we identified it.

The provider had failed to ensure the proper and safe management of medicines. This placed people at an increased 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.

Prior to the inspection the provider had identified concerns about the management of medicines at the home and had produced an action plan. Due to the nature of the concerns that we found during the inspection, we asked the provider to review this plan and the provider sent us a revised action plan the following day.
- Risks to people were regularly assessed and there were plans in place to help mitigate risks.
- The provider had a fire risk assessment and the people living there had personalised emergency evacuation plans written for them, identifying their needs in the event of an emergency. These plans were tested with regular fire drills.

● Regular checks were carried out on the fire alarm, emergency lighting and fire doors.
● Checks of equipment, water hygiene, gas, electrical and fire safety systems and had been carried out by registered contractors as required by law. Regular 'in-house' checks of, for example, hot water temperatures had taken place.

Staffing and recruitment
● At the last inspection we raised concerns about the staffing levels at the service. The provider took action and increased staffing levels in response. At this inspection we received mixed feedback from people about whether there were enough staff to meet their needs. One person told us, "When I need staff, they always assist me without delay." Another person said, "It takes so long for the staff to get us all up in the morning. The girls are sweating they are so hot. Just one more staff in the morning to help them would be good."
● Staff we spoke to during the inspection consistently said they felt that there was not enough staff to meet peoples needs. One staff member said, "I constantly feel rushed."
● We shared the mixed feedback with the provider who showed us the dependency tool that they used to calculate the staffing levels needed to meet people's needs. They also showed us the results of call bell surveys that showed people were being responded to promptly when they called for assistance. The provider said that they were in the process of reviewing how staff were deployed across the units.
● Staff were recruited safely. Recruitment files showed all pre-employment checks which included a Disclosure and Barring Service (DBS) check had been made to ensure only staff who were suitable to work with people were employed. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
● Systems were in place to protect people from harm. People told us they felt safe with the staff who supported them. One person told us, "I feel safe here, we are lucky to have such lovely staff."
● Relatives we spoke with said that people were safe at the home. One relative said, "The nursing and care staff appear to be knowledgeable and caring. They have given us no cause to worry that our relative is unsafe."
● Staff received safeguarding training and they were confident about how to report safeguarding concerns. One staff member said, "If I had any concerns that abuse was happening I would report them to my manager."

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong

● Accidents and incidents were reviewed to identify where lessons could be learnt, and actions were taken to prevent recurrence.

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

Supporting people to eat and drink enough to maintain a balanced diet

- People gave us mixed feedback about the quality of the food provided, some people and staff said the quality of food depended on which chef was working.
- During the inspection we saw that people who required their diet to be modified received meals that met their needs. A modified diet is a diet that is altered by changing food consistency or nutrient content or by including or eliminating specific foods.
- However, we did observe modified meals did not appear to match what had been described on the menu. We raised this with the management of the home, who confirmed that this had been the case and would ensure in future that accurate menus were provided for people to choose from.
- During a mealtime we observed a carer updating care notes whilst they were assisting a person to have their meal. The carer proceeded to use inappropriate language and make false statements to encourage the person to eat. We shared these concerns with the registered manager who took immediate action to address this with the staff member.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- We received mixed feedback from health care professionals that worked with the service. One professional said, "there are inconsistencies with repositioning frequencies, Waterlow scores and weights being monitored, for example 1 patient had lost 6.6kg in 2 months and the nursing staff were unaware of this and hadn't made any proactive approach to manage this." Waterlow assessments calculates the risk of pressure ulcers developing on an individual basis through a simple points-based system.
- Another professional said, "Yes the home do work well with myself, (they are) always willing to improve the logistics of my visits as and when required." "We have a good system of communication prior to and during my visit."
- During the inspection we checked the records of care provided and found that staff were following guidance from healthcare professionals.

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

- People's needs were assessed to make sure staff understood and were able to meet their needs. Nationally recognised assessment tools were used as part of the assessment process and care plans were developed from these assessments.
- Staff knew people well and could tell us about their individual support needs, preferences and choices.

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 MCA 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.

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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Assessments of people's mental capacity and best interests meetings had taken place where people lacked the capacity to make a particular decision to ensure decisions made were appropriate and the least restrictive. This related to the decisions concerning where a person should live, the use of bed rails and personal care.
- The registered manager had made appropriate DoLS applications for People who were deprived of their liberty at the home and lacked capacity to consent to these arrangements
- Staff confirmed they had attended MCA and DoLS training. One staff member said, "It's important we offer people choices to help maintain their independence."

Staff support: induction, training, skills and experience

- Staff completed an induction programme when they started to work at the service and continued to receive ongoing support and training to develop their knowledge and skills. New staff were given the opportunity to work alongside more experienced staff whilst they were getting to know the people they were supporting.
- People told us all the staff were well trained and had the skills and knowledge to meet all their needs.
- Staff were given the opportunity to discuss their individual developmental and work needs during one to one session's. These provided an opportunity for staff to discuss their role, training and any support they might require. One member of staff said, "The training and support is excellent."

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

- The design and decoration of the home was adapted to people's needs. Handrails were fitted around the home to ensure people could walk safely and corridors were wide enough to accommodate wheelchairs.
- People's bedrooms were adapted to their needs and personalised. People could choose to put an image on their door to help them to identify their rooms.
- Large clocks and pictures were placed around the home to help people to orientate. This design can lower stress for people living with dementia who may become disorientated.

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 our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained 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 our last inspection we found systems and processes in place were insufficient when reviewing incidents. Management and deployment of staff required further improvement to ensure appropriate staff levels were in place to monitor people safely. This was a breach of Regulation 17, section (1) (2a) (2b), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
At this inspection we found that the provider had made improvements, however, the governance systems were not providing effective oversight to ensure that the people's medicines were being stored and administered safely and as they were prescribed. The provider was still in breach of regulation 17.
- Governance systems and checks had failed to identify and take timely corrective action for the concerns we found around the administration of medicines at the home.
- Governance systems and checks had failed to identify that 1 person's rescue medication had passed its use by date.
- Systems and audits had failed to identify staff were not consistently checking and recording the temperature of the medication fridge in 1 unit.
- Systems had failed to identify that 1 person had not received a prescribed cream for over a month due to it being entered on the electronic system incorrectly.
- The provider had identified that the management of medicines required improvement and had developed an action plan prior to our inspection. However, this action plan did not address the immediate concerns we found in a timely manner.

The providers monitoring and governance process had failed to identify and take appropriate action in relation to the shortfalls in the administration of medicines at the home. This was a continued breach of Regulation 17, section (1) (2a) (2b), 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
- Staff we spoke to told us there was low morale in the staff team.
- The provider consulted with stakeholders about the service, to help identify improvements and to obtain

peoples wishes of how they wished their care to be provided.

● Meetings were held with people regularly. One relative told us, "My brother attends residents meetings where their views are sought on various matters."

● The provider sent out annual surveys to family members and had just received the results of the latest survey. The provider was in the process of analysing the replies to identify any improvements required.

● The registered manager told us they had a number of staff recruited from overseas. She explained that had proved beneficial as she has been able to match staff to people whose first language is not English.

● The registered manager told us the home had recently celebrated Pride week and had signed up to a local Charity, Safe Ageing No Discrimination (SAND), that was set up to challenge lesbian, gay, bisexual, transgender, queer (LGBTQ+) discrimination in the older community. As part of this, resources and information were available for people who used the service and staff.

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 registered manager was aware of their responsibilities under the duty of candour.

● Records of adverse incidents showed that the duty of candour was met as part of the providers review of incidents.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure the proper and safe management of medicines. This placed people at an increased risk of harm.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	This was a repeated breach. The providers monitoring and governance process had failed to identify and take appropriate action in relation to the administration of medicines at the home

The enforcement action we took:

We issued the provider with a warning notice, requiring them to make the required improvements by an agreed date to avoid further regulatory action.