Morven Healthcare Limited

Morven House

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 caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

The inspection of Morven House took place took on 25 and 26 November 2015. The inspection was unannounced.

At the previous inspection in February 2015 the service was not meeting the Regulations we inspected in the following areas: pressure ulcer management; appropriate training and support for staff; systems to actively seek the views and experiences of people using the service; and, effectively assessing, monitoring and improving services provided. We asked the service to provide an action plan outlining how they would improve to meet the Regulations. During this inspection we found the service had made improvements in all but one of these areas: effectively assessing, monitoring and improving services provided. We also found the service was not managing medicines safely and appropriately.

Morven House provides residential care for a maximum of 20 people who may be living with dementia. At this inspection 17 people were using the service. The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service did not always manage medicines safely and appropriately. You can see what action we told the provider to take at the back of the full version of the report. However, we did see some good practice in relation to medicines management. Staff knew how to recognise and respond to abuse. They knew how to report safeguarding incidents, escalate concerns and were aware of whistleblowing procedures. People's needs were assessed and risk assessments created. Risks were reviewed in response to changes in people's needs but were not subject to regular, periodic reviews. There were sufficient numbers of staff to meet people's needs.

Mental capacity assessments had been completed to identify each person's capacity to make decisions and consent to care and treatment. These assessments did not address fluctuating capacity. Staff had the skills, knowledge and experience to deliver safe care and treatment. They were supported with appropriate training and supervision to provide safe and appropriate care. People were supported to have a healthy diet and to maintain good health.

People using the service and relatives commented positively about staff. We saw staff were kind and respectful and had time for people. People and their representatives were involved in making decisions about their care and treatment. Staff respected people's privacy and dignity. People's wishes around end of life care and cardio-pulmonary resuscitation had been discussed and put into place.

People received personalised care. Care records were person centred and addressed social and healthcare needs. People were involved in the development of their care and treatment. There were systems to actively seek the views and experiences of people and their representatives about their care and treatment. There were activities to stimulate people. People and relatives were confident they could raise issues and concerns with the staff and manager.

Although there were a number of audits to assess and monitor service provision they were not always effective. Medicines audits did not identify errors in the management of medicines. You can see what action we told the provider to take at the back of the full version of the report. Staff meetings were held to pass on information and gather feedback.

Summary of findings

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 always safe. The service did not always manage medicines safely and appropriately. Staff knew how to recognise and respond to abuse. There were enough staff to support people's needs.

Requires improvement

Is the service effective?
The service was not always effective. Mental capacity assessments had been completed to establish each person's capacity to make decisions and consent to care and treatment but did not address fluctuating capacity. Staff received regular training and management support. People were supported to have a healthy diet and maintain good health.

Requires improvement

Is the service caring?
The service was caring. People spoke positively about their relationships with staff and we observed positive interactions between people and staff. People were involved in their care and treatment. Staff respected people's privacy and dignity.

Good

Is the service responsive?
The service was responsive. People received personalised care. Care plans were person centred and addressed a wide range of social and healthcare needs. People were involved in the development of their care and treatment. There were systems in place to seek the experiences of people about their care. People were confident that they could raise concerns with staff and management.

Good

Is the service well-led?
The service was not always well-led. The systems for assessing and monitoring the service provision were not always effective. Staff meetings were held to pass on information and gather feedback.

Requires improvement

Morven House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 25 and 26 November 2015 and was unannounced.

The inspection team comprised an inspector and a specialist advisor in tissue viability and nursing. Before the inspection we reviewed information we held about the service which included statutory notifications and safeguarding alerts and spoke with four healthcare professionals. We spoke with five people using the service, three relatives and five members of care staff along with the manager, senior manager, maintenance, laundry staff, domestic staff and a representative of the provider. We carried out general observations throughout the inspection. We looked at records about people's care and support which included nine care files. We reviewed records about staff, policies and procedures, risk assessments, minutes of meetings, complaints and audits.

Requires improvement

Is the service safe?

Our findings

We found the service was not always safe. We checked records for the management of medicines and found anomalies with the storage of controlled drugs; gaps in medicines administration charts (MAR); and, pro re nata medicines (PRN), commonly known as 'when required' medicines did not tally with records.

Medicines were stored securely in a locked cupboard. We saw one of the controlled drugs was with the general medicines. Controlled drugs should be stored in an approved and appropriately secured controlled drugs cupboard. Such a cupboard was available within the general medicines cupboard. The controlled drugs record book correctly recorded the administration of the temazepam being signed and countersigned by two members of staff. We asked the registered manager for an explanation but they were unable to provide one. When we checked a random selection of MARs we found two gaps in relation to the administration of antibiotics (amoxicillin) on 21 and 22 November 2015 at 1200 and 1700 respectively. Consequently, we were not assured the medicine had been administered.

We checked three random boxes of Paracetamol tablets against records. We could not account for the tablets in one box because there was no record on the MAR as to how many had been supplied or carried forward. Another box showed an initial supply of 100 tablets and the MAR indicated 70 tablets had been administered. However, instead of 30 tablets we found six. 24 tablets were unaccounted for. In a residential care home PRN medicines need to be accurately accounted for to ensure people do not exceed recommended dosages and particularly so in the case of Paracetamol.

The incorrect storage of controlled drugs and the errors in records relating to the amoxicillin and paracetamol were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite this breach there was evidence of good practice with medicines management. A few weeks prior to the inspection the service had moved to a monitored dosage system called Biodose that decreased the risks of errors when administering medicines. Medicines for individuals arrived from the pharmacist in a tray containing sealed pods of medicines, including liquids. Each tray displayed the name and photograph of the relevant individual. Each pod was colour coded to reflect the time of day for administering. The seal of each pod clearly showed the person's name, dosage date and time and an itemised list of the contents. Each MAR contained the person's name and photograph with dosage instructions.

People who could verbally express their experiences told us they felt safe. We spoke with staff who demonstrated a good understanding and knowledge about safeguarding people from abuse. Staff had completed relevant training and told us they would inform the manager of any concerns and were confident colleagues and the management team would deal with any concerns appropriately. Staff knew how to escalate concerns both within and outside of the service and were aware of whistle blowing procedures. Handovers took place between each shift where any incidents of note or concerns were passed on.

At our previous inspection we identified concerns about how the risks to people using the service were managed. This was specifically around the area of pressure ulcer prevention and management. We found staff had completed training on pressure ulcer management since that inspection. We spoke with staff about pressure ulcers and they demonstrated they understood the importance of prevention and gave us examples of what they were doing in a practical context. They encouraged people to mobilise regularly and change position when sitting to relieve pressure. They ensured continence was regularly managed and we saw people were quietly prompted and supported to visit the toilet. They were aware of the importance of barrier creams and sprays and told us how they used them. They were able to explain how they would recognise the early onset of a pressure ulcer or other skin changes and they had been directed to inform the manager of any such signs immediately. We checked care records and found Waterlow scores (a risk assessment tool to identify people at risk of pressure ulcers) had been completed. At the time of this inspection there was nobody at anything other than low risk and this was an accurate reflection of care records we examined. The service had made significant improvements around pressure ulcer management.

We found that other care and support plans for people using the service were underpinned with relevant risk assessments. The risk assessments reflected the needs and goals of each individual and covered a wide range of risks.

Requires improvement

Is the service safe?

These included areas such as personal emergency evacuation, nutrition, self-care assessment, malnutrition, and personal care. Although the risk assessments were completed we found they were not always regularly reviewed or updated. The service used a malnutrition universal screening tool (MUST) to identify the risk of malnutrition for each person using the service. One of the indices for the tool is body mass index which requires weighing people at least monthly to identify significant weight gain or loss (either being indicative of health problems beyond or associated with malnutrition). We found one care record where the person had not been weighed since June 2015 and any deterioration in their weight may have been missed. According to the National Institute for Health and Clinical Excellence nutritional screening in care homes should be done on admission and repeated monthly. In addition, the British Association for Parenteral and Enteral Nutrition recommended people at low risk of malnutrition should be weighed monthly.

There were sufficient numbers of suitable staff to care for people and meet their needs. Staffing levels had been increased since our previous inspection. When we arrived we found there were four care assistants and the registered manager providing care and support. A full time member of staff had been appointed to deal with people's laundry, a task that had previously been carried out by care staff. Care assistants were supported by domestic, catering and maintenance staff allowing them to concentrate on providing care and support. The registered manager was enabled to spend more time with care staff and people using the service through the appointment of a senior manager. The night shift had seen an increase from two to three members of staff. We were also told that recruitment to bank staff was taking place with advertisements already placed. The service had also contracted an agency to provide staff to cover short notices absence of staff such as through sickness.

We looked at staff records and policies and found there were robust procedures to ensure only suitable staff were employed. The senior manager had reviewed all the staff files and had renewed, or had applied to renew, Disclosure and Barring Service checks on each member of staff. When we looked at staff files we could see that each one had been audited to ensure appropriate documents were in place including references and identification documents.

We found that the service was a safe place for people, staff and visitors. The original building has been extended with an additional residential block and a large conservatory. The original building has been undergoing refurbishment and redecoration, a process that is ongoing. People using the service were happy with changes. One visitor told us their relative was delighted with the new curtains in their room. One person using the service said, "It is a beautiful place to stay, we really like it here."

The service had procedures to prevent and control infection. Permanent domestic staff worked to a cleaning schedule. We saw staff wear personal protective equipment when appropriate. We found staff had a good understanding of infection prevention. Staff said they washed their hands before and after attending to people. Waste was disposed in appropriate coloured bags. We checked the laundry which was clean and tidy. We spoke with laundry staff who demonstrated understanding relevant infection control procedures.

On the ground floor there were three toilets available to people using the service and visitors. Two had been completely refurbished and were easy to keep clean. People who required support were taken to the third toilet because it was larger. We found this toilet had not been refurbished and there was an unpleasant smell. We found the smell was due to the presence of a small plastic bowl that was stained. The bowl was removed. The floor was covered with a vinyl type floor covering. The floor covering did not meet the walls and was not sealed. There were gaps around the base of the toilet basin and other areas. We checked all surfaces of the toilet seat, inside and outside of the toilet basin and all surfaces of a support frame around the toilet basin. They were spotlessly clean. Although staff were quite obviously cleaning the toilet regularly the flooring could not be properly cleaned and presented a risk of infection. We were assured the toilet was due for refurbishment and in the meantime the flooring would be replaced. There were no infection concerns found elsewhere.

Requires improvement

Is the service effective?

Our findings

At our previous inspection we identified concerns about the inadequate training staff were receiving and the effect that could have on the delivery of safe and appropriate care and support. Since that time staff had completed a significant amount of training to support them with their role. The provider had also introduced e-learning that staff could use to complete training in the work place or at home. Staff told us they felt valued and supported. One member told us they had completed first aid training, fire training, medication training, mental capacity, moving and handling, person centred care and dementia training. They confirmed they had access to e-learning. Other members of staff had similar amounts of training. We spoke with the senior manager who ensured staff were informed of training dates and sent them reminders. We were also shown a matrix the provider was introducing to ensure training was clearly recorded and refresher dates met. Staff were able to obtain further, relevant qualifications. One member of staff told us the provider was supporting them to complete a Qualifications and Credits Framework (QCF) Level 3 qualification in Health and Social Care. Members of staff told us they recently had one-to-one supervision sessions. One said they had discussed training and welfare issues. We were satisfied that staff were receiving appropriate support to carry out their duties.

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. The application procedures for this in care homes and hospitals are 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 were being met. The service had completed mental capacity assessments with the GP to identify people's capabilities to make decisions in relation to end of life care. We found further mental capacity assessments elsewhere in care records. These mental capacity assessments were general and did not take into consideration fluctuating capacity. This meant people may have been denied the opportunity to make decisions they could make or could be making decisions about care and support without fully understanding them or the consequences. People should consent to care and support and that consent must be informed consent. We asked management to review the mental capacity assessments for everybody in line with the principles of the MCA to ensure the care and support provided was the subject of informed consent or taken in the person's best interests. The service had reviewed people using the service and had not considered it necessary to apply for any authorities under the Deprivation of Liberty Safeguards (DoLS). Some people using the service lived with dementia. We asked management to review decisions that had previously been made in relation to DoLS. The management agreed to review both mental capacity and DoLS.

People had sufficient food to eat and liquids to drink. People were provided with a balanced diet and, if necessary, specific dietary needs were accommodated. Care records showed the nutritional needs of people were met. We observed lunch in the dining room. People chose where they wanted to eat. Some people remained in the lounge. Lunch was served calmly and efficiently and people appeared to enjoy their lunch which they confirmed when we spoke with them later. Staff did not rush people and were not task focussed. People had sufficient time to eat and enjoy their meal. We saw hot and cold drinks were available throughout the day.

People were supported with their healthcare needs. We saw evidence of various healthcare professional's involvement with the service within people's care records including the GP, district nurses, optician, physiotherapist, dentist and podiatrist.

Good

Is the service caring?

Our findings

We spoke with people about their experiences of care and support at the service. One person told us, “They are very good here, they are very nice.” A visitor said, “Nothing is too much bother for the staff. Now there are more staff there is far more talking with residents.”

We observed actions of staff and listened to interactions between people and staff throughout the inspection. Staff were kind and treated people with respect. We saw staff taking time to chat with people and interact with what they were doing. The positive body language and responses from people to staff reflected the comments made to us about staff. Staff were aware of people’s needs. When we arrived, people in the lounge area were smiling and alert. They were engaged with what was going on around them. It was noticeable that staff were more relaxed than on our previous inspection where they were very much task focussed. When we spoke with staff they told us they were happier because they had more time to deliver care and support as there were more staff on duty. When they needed to deliver care and support staff clearly explained to people what they wanted to do and provided verbal and appropriate tactile reassurance. People were asked to do things. Staff made eye contact with people when they were talking and if people were sitting made sure they were at the same level.

We saw people were involved in the planning of their care and support from entries in care records. One relative told us they were involved in all aspects of their relative’s care. We saw people’s choices and preferences were recorded. Staff were able to tell us about people’s preferences and choices such as what people did not like to eat, how they preferred to dress and so forth. The senior manager was communicating with people and visiting relatives to update and clarify people’s choices and preferences to improve the provision of person centred care and support. We saw examples of new care plans being introduced that emphasised people’s involvement and their preferences and choices around how care was delivered.

We found staff respected people’s privacy and dignity. Call bells were answered promptly so people were not left feeling uncomfortable or undignified. Staff knocked on people’s doors before entering. Personal care and support was delivered in private. People were appropriately dressed and it was evident from our observations they were encouraged and supported with maintaining cleanliness and hygiene. A relative told us, “I have never had any concerns about my [relative’s] cleanliness.”

The service was still being supported with providing end of life care by a local hospice. We saw some people had ‘do not attempt cardiopulmonary resuscitation (DNACPR)’ notice in their care plans. These were up to date and correctly completed. The GP had been involved with assessing people’s capacity to make these decisions and speaking to close relatives. Relatives confirmed they had been involved in discussions about DNACPR.

Good

Is the service responsive?

Our findings

At our previous inspection we identified concerns that the service did not have systems in place to actively seek the views and experiences of people using the service and those acting on their behalf. We found the service had made improvements in this area and planned to make further improvements to increase feedback to drive improvement in the service. Feedback forms were displayed by the entrance. We noted in the minutes of a staff meeting they were asked to encourage people and visitors to complete the forms. We saw evidence of involvement in care plans. We were told a relatives meeting had been planned. A visitor told us they felt more involved in what was going on. The service had policy and processes to deal with complaints. The complaints procedure was included in the service user guide. There was also a poster on display in the foyer opposite the door with a bold title stating "It is okay to complain." There was also a flier explaining how to complain. These had been introduced since our previous inspection. There were no complaints recorded but the manager and senior manager favoured an open door approach in order to address concerns at an early stage. The service was looking at other ways to survey the experiences of people using the service and their relatives.

We looked at care records and saw they were person centred and addressed a wide range of people's needs. The care records contained risk assessments for each person and focussed on people as an individual. They were reviewed in response to changes in people's needs but were not subject to regular, periodic reviews. We found staff had completed person centred care training which emphasised the necessity to do things with people rather than to people. Care records were written in the first person emphasising the fact that each record referred to an individual person. Records contained sections on 'This is me,' lifestyle and interests and preferences. The records, training and the increase in staffing levels meant the service was initiating a culture of person centred care.

People were assessed before they came to live at the service unless they were admitted as an emergency. The assessment along with other admission information provided the basis for planning care and treatment for people. We found care records were not being reviewed on a regular basis. The service had previously reviewed these records once a month or when required. Although there were responsive updates we found there was no system of periodic reviews operating. As the service provided care and support for older people who might live with dementia we expected periodic reviews, for example once a month, because these groups of people are prone to changes in their needs. Periodic reviews, unlike responsive reviews to obvious needs, could identify more gradual and less obvious changes in people's needs. We were shown changes that were about to be introduced to the format of care records and were reassured by what we saw that periodic reviews would take place. We were assured immediate steps would be taken to ensure the care records were reviewed for each person.

At the last inspection we noted there was very little in the way of organised activities for people using the service. Activities were important to reduce the risk of people becoming isolated, bored, frustrated or unhappy. One member of staff worked two afternoons a week as the activities coordinator. The activities coordinator had not had any training to deliver activities and the planned activities that did take place were quite basic and limited. At that time, staff tended to be task focussed and had little time to engage people in activities. During this inspection, we saw an activities timetable had been introduced and discussed at a staff meeting. More staff were on duty to provide care and support for people. One relative told us, "There's been a lot of changes, a lot of good changes. There are more activities taking place." We spoke with staff who confirmed they were more involved in activities because the increased staff levels gave them the time to do so. We were shown an activities book that recorded what activities had taken place and who had taken part.

Requires improvement

Is the service well-led?

Our findings

The service was not always well-led. At our previous inspection we identified concerns the service did not have effective systems in place to make sure the quality of service they provided was regularly monitored and assessed to prevent inappropriate or unsafe care. There were a number of internal audits and reviews carried out by the manager to monitor and assess the quality of service provided. However, the provider did not have other systems in place to identify any failings in these reviews and audits. There was no evidence the provider was seeking, recording and assessing feedback about experiences of the service from a wide range of stakeholders in addition to people using the service, staff and relatives such as visiting professionals, service commissioners.

We found there had been some improvements but there were still some concerns. For example, since our previous inspection there had been two audits on the administration of medicines in April and August 2015. Apart from these intervals being too far apart to effectively ensure medicines were managed safely they were of the tick box variety. Tick box audits do not encourage a probing audit because they only ask for a yes or no tick in response to direct questions. Despite the concerns we identified in the previous inspection this medicines audit failed to identify the mistakes picked up in this inspection. The audit failed and there was still no system in place to identify that failing. This could also be applied to the periodic reviews with care plans and risk assessments. This did not give us confidence in other checks, reviews and audits being carried out by the service that they would identify where there were mistakes or where they needed to improve. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see there were audits such as a monthly health and safety audit and a kitchen audit. The senior manager told us they intended to review the system of auditing and were also developing a contingency plan.

At the previous inspection we found there had not been regular staff meetings. One staff member said there had not been a meeting for months. We were sent minutes that were undated and the contents suggested it was a one way communication with instructions being given to staff and no feedback recorded. During this inspection we found staff meetings were once again taking place. They were attended by the provider as well as the management team and were timed to enable some of the night staff to attend. The senior manager showed us the date of the next planned meeting and showed us meeting minutes. As one member of staff told us there was "…a two way communication," with staff being encouraged to be involved and feedback. Staff told us they felt more valued and supported with the changes that had taken place.

The manager and senior manager were both very visible throughout the service. They operated an open door approach and were readily available to people using the service, relatives, visitors and stakeholders. Representatives of the provider were also regularly found at the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not ensure the safe and proper management of medicines. Regulation 12(2)(g).**

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 The provider did not have effective systems and processes in place to ensure the quality of service provided was regularly monitored and assessed to ensure that they were able to meet other requirements in this part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulations 4 to 20A).

The enforcement action we took:
A formal warning notice was issued to the provider requiring them to make improvements by 10 April 2016.