

Valorum Care Limited

Mickley Hall - Care Home with Nursing Physical Disability

Inspection report

Mickley Lane
Totley
Sheffield
South Yorkshire
S17 4HE

Tel: 01142369952

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13 May 2020

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Inadequate ●

Summary of findings

Overall summary

About the service

Mickley Hall is a nursing home registered to provide accommodation and nursing care for up to 40 people who have physical disabilities. At the time of the inspection 35 people were using the service, some of whom also had a learning disability.

People's experience of using this service and what we found

The service did not apply the principles and values of Registering the Right Support and other best practice guidance. This guidance helps ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice and independence.

Both the providers representative and the manager did not have knowledge of the values and principles of Registering the Right Support. This had a negative impact on people and did not always meet their needs.

People lived in an environment that posed some risks to their health, safety and well-being. Risk assessments were not always effective because they were not frequently updated to reflect people's current needs. Systems to receive, store, administer and dispose of medicines were safe. However, records relating to the management of medicines were not safe

The deployment of staff needed to be reviewed to ensure those people who required more support were not left unattended. We saw some staff had not been provided with relevant training. Therefore, some staff did not have the skills they needed to undertake their role.

Safe recruitment procedures were being followed. Overall people told us they felt safe in the care of the staff. Staff had a good understanding of abuse and their responsibilities in keeping people safe.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice. Staff knew how to respect people's privacy and dignity.

A number of activities were available to people. Further work was required to ensure these were available more often and were person-centred and meaningful to people.

The systems in place to assess, monitor and improve the quality and the safety of the service were ineffective in practice. The provider did not have effective oversight of the service to drive improvements which practice. Which meant governance systems were not robust or effective.

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 13 April 2019). Since this rating was awarded the registered provider of the service has changed.

Why we inspected

The inspection was prompted in part due to concerns received about staffing levels, quality of care and people's safety. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see all sections of this full report.

We have identified breaches in relation to safe care and treatment, person centred care, consent, staffing and leadership at the service.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority commissioning and safeguarding team to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate ●

Mickley Hall - Care Home with Nursing Physical Disability

Detailed findings

Background to this inspection

The inspection

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

Inspection team

The inspection team consisted of two inspectors, an inspection manager 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

Mickley Hall 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.

At the time of our inspection a manager was still registered with the Care Quality Commission. However, five months before our inspection, they left the home and were no longer in day-to-day control. Since the registered manager had left, another manager had been appointed. The manager was in the process of registering with CQC.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered 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.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

Prior to the inspection visit we gathered information from a number of sources. We also looked at the information received about the service from notifications sent to the Care Quality Commission by the manager.

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 six people who used the service and three relatives about their experience of the care provided. We spoke with 11 members of staff including the manager, deputy manager, nurses, care workers, activities coordinators, the admin worker, the housekeeper and the maintenance man. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service.

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 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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People did not always receive personalised care which met their needs. For example, one person's care records said they had no allergies. However, in another section it stated they were allergic to specific medications. When there is inconsistent information available there is an increased risk that people will receive inappropriate care and may be harmed. We discussed this with the manager who said they would take immediate action to address these concerns and to ensure people's care records held accurate up to date information.
- Risks assessments were not always followed, putting people at risk of harm. For example, one person had a detailed assessment completed by the speech and language therapist (SALT) which gave staff clear instructions that the person was nil by mouth. Records showed that there had been five incidents when the person had eaten food or drink. This meant the person had been put at risk of harm.
- Risk assessments had not been reviewed or routinely updated when accidents had occurred to ensure risks were assessed and reduced.
- Some people did not have access to a call bell due to these being out of reach. Therefore, they would not be able to summon help if required.
- Environmental risks were not always appropriately managed to ensure safety. For example, we found store rooms, sluices and medication stores left unlocked, so anyone could access these areas putting people at potential risk of harm.
- Accident and incident analysis was not effective.
- There was no evidence that trends or patterns were being identified and actions taken to reduce risks in relation to people's care. For example, one person had been found wandering outside on a number of occasions. The provider had failed to analyse the incidents. This showed the provider had failed to ensure action was taken to mitigate those risks.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was also a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- There were not sufficient staff deployed to ensure people always received safe and timely support.
- During this inspection we identified long periods of time where people were left sitting in the lounge with no staff present. It is important to have staff supervision on hand to respond to people if they show any signs of distress through facial expressions or coughing. Without a staff member in place people were left at risk.

- There were enough staff to provide basic care, but limited time was available to engage with people in a meaningful way.
- The service often ran short staffed or with high levels of agency. The home was actively recruiting in order to provide consistency of care and reduce the use of agency staff. Staff told us that this made their job harder as agency staff did not know how to support people in line with their assessed needs. One staff member said, "One of the obstacles to my work is having to look after the agency workers."
- The provider used a staffing assessment tool to calculate the number of staff needed for each shift. We spoke with the deputy manager, they said they used a dependency tool could not clearly explain how this was used. They told us if they are full would have 12 staff in the morning and eight in the afternoon. They went on to say, "We have four empty beds at the moment, so we are doing 11 and seven."
- There were only ten staff on duty on the morning of our inspection, we asked why there was not 11. The deputy manager told us the service had two student nurses shadowing and had been included in staff numbers. This showed the systems in place to ensure there were sufficient staff deployed was ineffective in practice. The students were placed to observe not be included in the staffing numbers. The manager assured us they would review the dependency tool to ensure people received appropriate support and supervision and that the approach they used reflected current legislation and guidance.

The provider had not taken appropriate steps to ensure staffing levels and the deployment of staff were sufficient to always meet people's needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider followed a robust recruitment process.

Systems and processes to safeguard people from the risk of abuse

- We received mixed feedback from people about whether they felt safe. Overall people told us they felt safe although other comments included, "I don't feel safe, I hate it people [care staff] have got no time." Another person told us they were not happy with their placement at the service and felt they were not appropriately supported. We discussed these concerns with the manager who said they would take immediate action to investigate these concerns with the people concerned and the commissioning authority.
- The registered manager had referred safeguarding incidents to the local authority safeguarding team and to the Care Quality Commission.
- The manager kept a log of these incidents; however appropriate action had not always been taken by the management team to reduce the risk of repeat events.
- The services key performance indicator training records showed that only 75 percent of staff working at the service had completed safeguarding vulnerable adults training at the service. It is important that all staff complete training and this is regularly updated so they have a good understanding of their responsibilities to protect people from harm.

Preventing and controlling infection

- Predominantly people were protected by the risk and spread of infection. We completed a tour of the home and found many areas had been refurbished, including bathrooms, sluices and some communal areas. There were still improvements required and the manager told us the provider intended to continue the improvements.

Using medicines safely

- Medication procedures were in place and predominantly followed to ensure people received their medication as prescribed. Time specific medication was given at correct times. People we spoke with told us staff supported them with their medication.

- Protocols were in place to guide staff when to administer medication to meet people's needs. However, protocols for medication to be given as and when required lacked detail to guide staff and some people did not have a protocol in place. There was a risk that people who lacked capacity to tell staff when they required their medication may not receive their medication when required.
- Medication audits were carried out to ensure compliance with procedures. We found these had been completed. However, had not identified the lack of detail in protocols. We discussed this with the nurses and the manager, and they agreed to ensure adequate information was detailed in medication protocols.

We found no evidence that people had been harmed however, medicines recording systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a further breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.



Is the service effective?

Our findings

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

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

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

- People's needs, and choices were not always assessed, and care and treatment were not always delivered in line with current legislation and best practice standards. For example, one person had a detailed assessment completed by the physiotherapist which stated that two people were required to support with moving and handling. However, records we reviewed showed there had been occasions when staff did not follow the physiotherapists guidance.
- People had assessments of their needs completed, but these were not reviewed and evaluated on a regular basis to ensure they met people's changing needs. We spoke to the manager about this concern and they agreed that the care records needed reviewing and updating as a matter of urgency. We saw that this had led to inappropriate care as referenced in the safe and well led domains.
- Staff did not always know people's needs or how to support them safely. Some people required high levels of support for both personal and social care. One care worker told us, "I have never read any of the care plans including [person who used the service] I don't know their life story." Leading to people potentially receiving unsafe care.

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

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

- People received food and fluid which supported them to maintain a healthy balanced diet. The meal was well presented. People told us the food was very nice. However, the mealtime experience was not person-centred, and it was institutionalised, there were set mealtimes in a large communal dining area. In addition, people did not have access to the dining room outside of these times. For example, one person could not go in the dining room when lunch was finished, there was no reason why they could not as they were with staff to ensure their safety.
- Staff served drinks and snacks at set times only which did not demonstrate the provider supported a person-centred approach to supporting people.

This was a breach of Regulation 9 (Person Centred Care) of the Health and Social care Act 2008(Regulated Activities) 2014.

Staff support: induction, training, skills and experience

- Staff had not been provided with the relevant training and, so they had the skills they needed to undertake their job.

- Nursing staff had not always been provided with specialist clinical training they required. For example, the service provided support to people living with a tracheostomy, but the nursing staff had not been provided with tracheostomy training. We discussed this with the manager and asked them to take immediate action to source the specialist training. Following the inspection, the manager contacted us to say they had arranged the training.
- The staff training matrix showed that some staff were not adequately trained and may not have the skills, knowledge and competence that is required for them to do their job. For example, the training matrix showed that some care workers had not completed training in safeguarding, moving and handling and infection control.

We found no evidence that people had been harmed however, the provider had failed to ensure all staff had received appropriate support, training, professional development, as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

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

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

- The provider had failed to establish robust processes to ensure valid consent was always obtained and the principles of the MCA were not consistently adhered to. This meant people's legal rights were at risk of not being upheld.
- Staff and management did not have an oversight of who had an authorised DoL's in place or if there were any conditions attached to authorisations.
- Where people lacked capacity to make specific decisions no best interest decisions had taken place. We discussed this with the manager who looked for these but could not find them. This meant people could be deprived of their liberty unlawfully.

This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- There was evidence of staff involving other professionals in people's care, such as district nurses, dieticians, speech and language therapists and GPs as and when their support was needed.

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

- Overall people's individual needs were met by the adaptation, design and decoration of the service. The service was homely and spacious and had a range of communal spaces which were used for a range of activities. However, there were large communal areas that were not conducive to meet the complex needs of people who used the service. The layout of the building did not meet the principles of registering the right

support. For example, people with a learning disability benefit from smaller more personalised settings with easy access to the local community.

- Although, the premises had been upgraded in areas, we found areas that required attention. For example, the activities room included a computer room, a kitchen area for baking, a music area and an arts and crafts area. However, the craft room was cluttered and untidy. We discussed this with the manager who said they would take immediate and responsive action to address the concerns with the premises.
- There was an outside area that was accessible to the people who lived at the home.

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 gave us mixed feedback about the service. Comments included, "Some people should not be living here. They are too independent, it is not personalised for them," and, "Yes, they [staff] do care."
- Despite the concerns identified during the inspection, staff did their best overall, and as much as they were able to influence, to make sure people were cared for.
- Staff had a kind and caring approach and a good rapport with people and knew about some people's personal histories.

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

- People and their relatives were supported to share their views in a 'you say, we did' process. For example, one relative asked if the carpet in their relative's bedroom could be replaced because it was an infection control risk. In response to this the service had developed a refurbishment plan that included replacing all the bedroom carpets.
- Overall people we spoke with had not seen their care plan or been involved in their reviews. Only one person said, "Yes, I have seen it [care plan], I am aware of it."

Respecting and promoting people's privacy, dignity and independence

- Overall people told us they were treated with dignity and respect. Comments from people included, "I am in bed, so, they [staff] make sure I am covered in the appropriate places," and "They [staff] knock on the door before entering."
- Staff were aware of maintaining people's confidentiality and did not speak about people in front of other people. People's personal information was stored appropriately.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

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's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People's care plans did not always contain sufficient, relevant and up to date information to provide care and support. Opportunities to ensure people received personalised care were missed because documents used to gather information about people were not completed. We found evidence that people had not received appropriate and safe care because of poorly maintained records.
- Care records had historical information about people to support staff in learning about them. Information such as what was important to and for the person, things they were proud of and important people in their life were identified.
- Staff feedback showed some agency staff did not always know how to support people.
- People had access to some activities, but they were not person-centred or provided regularly. Records of people's care did not always include information about their engagement in meaningful activities.
- People gave us mixed feedback about the range of activities. Some people told us they had opportunities to go on activities within the community. One person said, "I go on loads of activities. crystal peaks, the zoo, Nottingham, Leeds armouries." Another person said, "I would like to go out more."
- People were seen to spend large amounts of time unoccupied, with televisions playing without people actively watching them or engaged in any other types of pastime. It was not evident how people's preferences, interests and hobbies had been considered. This did not promote or provide person centred care.

This was a further breach of Regulation 9 (Person Centred Care) and Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were identified, recorded and highlighted in care plans.
- People using the service would benefit from the provider developing more user-friendly information. For example, using pictures and photographs as a way of communication.

Improving care quality in response to complaints or concerns

- The provider had a system in place to ensure people could raise concerns about the service.

- The manager kept a record of complaints raised and could evidence they had addressed complaints appropriately.
- Overall people and relatives we spoke with felt if they had any concerns or complaints they would be listened to.

End of life care and support

- There were end of life care arrangements in place to ensure people had a comfortable and dignified death.

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Since the last inspection the provider of the service had changed. The registered manager had resigned from their position and there was a manager who was in the process of registering with CQC. People and staff gave positive feedback about the manager, but there was limited oversight by the provider.
- During the inspection we identified breaches relating to safe care and treatment, staffing, person-centred care, the need for consent and good governance. This showed the systems in place to assess, monitor and improve the quality and the safety of the service were ineffective in practice. The provider did not have effective oversight of the service to drive improvements which meant governance systems were not robust or effective.
- The provider had not ensured all staff received sufficient training to enable them to carry out their duties.
- The provider had failed to ensure there were effective systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people. The provider and manager were not maximising opportunities to continuously learn and improve because monitoring systems were not used effectively.
- People's care records were not all up to date and did not reflect their individual care needs or preferences. This put people at risk of inappropriate and unsafe care and support. The auditing of care plans had not picked up on these shortfalls.
- We discussed Registering the Right Support and Building the Right Support guidance with the manager and the provider. Registering the Right Support is based on the principles of choice, promotion of independence and inclusion and are fundamental to what a good service looks like for every person with a learning disability. The provider and the manager did not have any knowledge of Registering the Right Support guidance. The provider's lack of knowledge and therefore understanding of such guidance had resulted in them not being able to demonstrate how the service had embraced and promoted, choice, inclusion, control and independence for people with a learning disability living at the service.
- Governance and oversight systems had failed to ensure the provider was working consistently in line with the principles of the Mental Capacity Act (2005).
- One staff member told us, "There is not a lot of support from the provider, good support from management here, but we don't really see the provider, I am disappointed with them since the change."

This was a further breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Throughout the inspection the manager was honest and open with us. They acknowledged the shortfalls identified at this inspection and were eager to put processes in place to ensure people receiving care and support were safe and protected from harm.

Working in partnership with others

- The manager worked with other professionals and responded appropriately.
- Feedback from service commissioners was that although there were some positives there were areas that required further work. For example, audits needed to be more robust, accidents and Incidents analysis needed to be developed further and quality assurance systems needed to be further embedded.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Systems and practices did not promote person centred care.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The registered provider had not ensured, where a person lacks mental capacity to consent to their care, that a best interest process in accordance with the Mental Capacity Act 2005, Deprivation of Liberty Safeguards was followed.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm.
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	There was a lack of appropriate governance and risk management framework and this resulted in us finding multiple breaches in regulation.
Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had failed to ensure all staff had received appropriate support, training, professional development as is necessary to enable them to carry out the duties they are employed to perform.