Care Quality Commission

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?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection of Morven House took place took on 9, 10, 11 and 20 February 2015. The inspection was unannounced.

At the last inspection published in June 2014 we asked the provider to take action to improve parts of the building and outside areas which have been completed.

Morven House provides residential care for a maximum of 20 people who may have dementia. At this inspection 12 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 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.

People at the service felt safe. Staff knew how to recognise and respond to abuse. They knew how to report safeguarding incidents and escalate concerns if necessary. People's needs were assessed and corresponding risk assessments were developed. However, we found that risks identified in relation to

Summary of findings

pressure ulcer prevention and management were not acted on and staff lacked knowledge and training in these areas. You can see what action we told the provider to take at the back of the full version of the report. There were sufficient numbers of staff to meet people's needs. Medicines management was safe and people were receiving their medicines safely and as prescribed.

Staff generally had the skills, knowledge and experience to deliver safe care and treatment. However, we were concerned that individual staff members had not been supported with appropriate and up to date training to deliver safe and appropriate care and there had been no recent training in certain specific areas of care such as moving and handling. You can see what action we told the provider to take at the back of the full version of the report. Mental capacity assessments had been completed to establish each person's capacity to make decisions and consent to care and treatment. People were supported to have a healthy diet and to maintain good health.

People commented positively about their relationships with staff and we observed examples of positive interactions. People and their representatives were involved in making decisions about their care and treatment. Staff respected people's privacy and dignity.

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. Care plans and associated risk assessments reflected their needs and preferences. However, the provider did not have systems in place to actively seek the views and experiences of people and their representatives about how care and treatment met their needs. There was a limited range of activities to stimulate people. People and relatives were confident they could raise issues and concerns with the staff and manager.

Although a number of internal audits were carried out to assess and monitor service provision it was apparent that they were not always effective as seen in pressure ulcer care, training and seeking experiences of people using the service.

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. Staff knew how to recognise and respond to abuse. However, risks identified in relation to pressure ulcer prevention and management were not acted on and staff lacked knowledge and training in these areas. There were enough staff to support people's needs. Medicines were administered appropriately.

Requires improvement 

Is the service effective?
The service was not always effective. Staff received regular training and management support. However, Mental capacity assessments had been completed to establish each person's capacity to make decisions and consent to care and treatment. 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?
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. However, there were no systems in place to actively seek the experiences of people about their care. People were confident that they could raise concerns with staff and the manager.

Requires improvement 

Is the service well-led?
The service was not always well-led. The existing systems for assessing and monitoring the service provision were not effective.

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 9, 10, 11 and 20 February 2015 and was unannounced.

The inspection team comprised two inspectors, a registration inspector and a specialist advisor in tissue viability. Before the inspection we reviewed information we held about the service which included statutory notifications and safeguarding alerts and spoke with two healthcare professionals. We spoke with two people using the service, four relatives and five members of staff including the manager. We carried out general observations throughout the inspection. We looked at records about people's care and support which included 12 care files. We reviewed records about staff, policies and procedures, general risk assessments, accidents and incidents, minutes of meetings, complaints and service audits. We inspected the interior and exterior of the building and equipment used by the service.

Requires improvement

Is the service safe?

Our findings

The service was not always safe. People's needs were assessed before they arrived at the service. We looked at care plans and saw there were risk assessments in place for people using the service. These met people's needs but there were exceptions. Before we inspected the service we were aware a safeguarding had been raised in October 2014. A person using the service was found to have severe pressure ulcers when admitted to hospital with an unrelated condition. We looked at risk assessments with pressure ulcers in mind and saw that an appropriate Waterlow risk assessment tool had been completed and a Waterlow score identified for each person. It was not apparent what plans of care had been put in place for people who had been identified as being at risk from pressure ulcers. It was also not clear in records what had happened in relation to pressure ulcer prevention, recognition and management for the person who was found to have pressure ulcers when admitted to hospital. We spoke with staff who told us that they had not had any training in relation to pressure ulcers. Towards the end of our inspection we became aware of another case of pressure ulcers being found when a person using the service was admitted to hospital.

In these circumstances we decided to return to the service with a specialist advisor to look more closely at the service's approach to pressure ulcer care. We looked at the care plans for all twelve people living at the service and their Waterlow risk assessment. The Waterlow risk assessment is a tool used to identify and categorise those at risk of developing a pressure ulcer. Any person with a score above 10 to 20 is at risk or high risk of developing pressure ulcers and should have a prevention plan in place including use of appropriate equipment. The service had identified four people at risk of developing pressure sores in their scoring of the Waterlow assessment in addition to one person who was already being treated by district nurses for a pressure ulcer. There was no preventative care planning in place for these people or system for monitoring their skin integrity. In relation to those people identified as being at risk there should have been a preventative care plan in place that included the use of pressure relieving mattresses, chairs or cushions and turning charts.

We spoke with the manager and it became clear that they were unaware of the importance of the Waterlow score and lacked awareness and understanding of how to use the tool to identify people at risk from developing pressure ulcers. Although Morven House was a residential care home and not a nursing home staff should have had a good knowledge about pressure ulcer prevention, early recognition and management. We looked at the care records including daily records of the person at the service who was being treated for a pressure ulcer. The records did not show when the pressure ulcer was first identified. There were no body maps. The district nurse was managing treatment of the pressure ulcer. The person was being supported with a pressure relieving mattress in bed and a pressure cushion when sitting down. We found the pump for the mattress was under the bed and difficult to reach when it should have been visible to staff so that they could monitor the effectiveness of the mattress. We found that the mattress was working effectively but there were no records to show that it was being monitored. It was apparent that there was an immediate need for staff training at all levels in pressure ulcer prevention and management. We fed this back to the manager who assured us that training would be arranged as quickly as possible and it has since been confirmed that the training has been completed. We also informed the manager that immediate action plans should be put in place for those people at risk of developing pressure ulcers. Taking all of these factors into consideration this was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who could communicate verbally told us that they felt safe. One person said, "Of course I feel safe, I wouldn't be here if I didn't." Another person told us, "The staff are good, they look after us." Relatives we spoke with raised some concerns around staffing levels at certain times. One relative told us, "Quite often there is nobody in the lounge in the mornings." One care worker said, "People are safe." One professional told us that people were safe.

We spoke with staff about safeguarding people from abuse. They knew how to recognise the types of abuse and how to report them. They were aware of the ways in which they could escalate concerns including whistle blowing. Staff told us they had completed training about protecting vulnerable adults from abuse and were aware of their personal responsibilities to protect people from the risks of harm and abuse. We found that there was a handover

Is the service safe?

between the outgoing and incoming care staff where information was passed on about how people were feeling and behaving, any concerns about people and incidents that may have occurred in the preceding shift.

At our previous inspection we found the provider was in breach of the 2010 Regulations because they had not ensured that people using the service were in safe, accessible surroundings that promoted their well-being. This was due to the construction of a large extension that overran the completion date a number of times. Consequently, people did not have access to outside spaces, the driveway was heavily rutted and building works had impacted on the interior of the existing building. We found on this inspection that the extension had been completed and linked with the old building. The outside spaces had been landscaped with decking platforms and small areas of garden. The driveway had been renewed with the addition of car parking. In the old building we found that the major areas of concern had been addressed. The glass areas of a large dining room window which was looking onto a breezeblock wall during the building works had been replaced with mirrors that made the room brighter. The decorative ceilings that had been reinforced with plywood had been uncovered and added to the character of the building. We saw that there was new carpeting on the stairs and in some of the bedrooms and the visitor's toilet on the ground floor had been refurbished. There was still an ongoing programme of refurbishment in the old building. The provider had employed a full time maintenance worker and we visited every room with them, including unused rooms and identified areas for improvement. We checked hot water in a random selection of rooms. In one bathroom the water appeared to be too hot but a check with the thermometer showed that it was at an appropriate temperature. The maintenance worker informed us they were working through the building and had been told to carry out whatever repairs or refurbishment was needed. In relation to the new building the provider was making some changes to unoccupied rooms with a view to increasing the numbers of people who could live there. There was a new call bell system for both the old and new buildings.

One member of staff and two visitors told us there were times when there were shortages of staff. Two members of staff said there were no problems with staffing. The manager said there were no issues around staffing levels and we were provided with the staff rotas. The manager told us that they did not use agency staff which was confirmed by other staff members and visitors. The care staff were supported by two domestic staff for six days a week, two catering staff covering between 8.00am to 6.30pm during the week and an activities person for two half days in the week. During the day there were three care staff working 8am to 8pm and one working 8am to 2pm. One of these members of staff was responsible for the laundry. At night time there were two care workers. There were no sleeping staff at night. On one of the days when we were inspecting one member of staff had called in sick. The manager told us that she had arranged for another member of staff to come in later in the day and in the meantime the manager was covering the absence. Apparently, any short notice absences were covered in a similar way. There was a low turnover of staff at the service and they had a good knowledge of people using the service.

Medicines were managed safely. They were stored securely and administered from a medicines trolley. The service also had appropriate, secure storage for controlled drugs should if they were prescribed. Medicines were administered by appropriately trained staff. We looked at records for medicines received, administered and disposed and did not find any discrepancies. None of the people using the service were prescribed controlled drugs. None were self-medicating or being given covert medicines. There was an up to date medicines policy to provide guidance for staff.

Requires improvement

Is the service effective?

Our findings

The service was not always effective. We spoke with staff who told us that they had regular training. One member of staff told us they had not had first aid training. We asked to look at training records and were provided with a file containing training certificates. The manager told us that they were in the process of transferring records onto a new computer system as they had problems with the previous computer system. We made a record of the certificates and asked for a copy of the training matrix or records to be sent to us. We were sent a table entitled 'Training Certificates' that listed staff and training dates which reflected the record we had made. We saw that there were gaps in training. For example, only the registered manager and two lead carers had completed training in mental capacity. There was no record of moving and handling training yet there was a hoist that was used by staff for transfers. There was no record of training for the three regular night shift workers about safeguarding vulnerable adults. There was no logical system for identifying what training was needed by each member of staff or when refresher training was required. We were concerned that staff might not have appropriate and up to date training to support them to deliver safe and appropriate care to people. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that staff were registered for a dementia course but no details had been confirmed at the time of the inspection. Staff told us they had received leaflets about the course. Staff held a Level 2 National Vocational Qualification (NVQ) in Health and Social Care or were in the process of completing a Level 2 Qualifications and Credits Framework (QCF) in Health and Social Care. One member of staff told us they had almost completed their Level 2 which involved workplace assessment. One of the lead care workers was completing a Level 5 QCF in Leadership and Management. The manager was a registered mental nurse, with a Level 4 NVQ in Health and Social Care and Level 3 NVQ in Business Administration. We were told by the manager that staff were supported with regular periods of supervision.

The service had completed mental capacity assessments to identify their capabilities to make decisions and consent to care and treatment. The GP was involved in the assessments in relation to advance care planning. 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). The manager and one of the staff had attended workshops arranged by the local authority in relation to changes in interpretation of the legislation relating to DoLS as the result of a Supreme Court ruling in March 2014.

People had sufficient food to eat and liquids to drink. At all times during our inspection people had a glass of juice of their choice within reach which was regularly topped up. One person told us, "The food is quite good but I don't eat as much as I used to." One regular visitor said, "The food looks appetising, two veg, they provide alternatives for people who don't like dinner." We observed two lunch periods in the dining room. The food served was hot and people appeared to enjoy it. Mealtimes were prioritised and not interrupted by other activities or tasks. We saw there was a nutritional assessment sheet in care plans which identified if there were nutritional risks to individuals.

People were supported with their healthcare needs. They were registered with a local GP's surgery. The GP came out to the service when needed. We saw evidence in care plans of people being supported with appointments for the dentist and optician. There were visits from other healthcare professionals such as the district nurse when required. People were weighed once a month. We saw one care plan where weight loss had been identified and the care plan had been reviewed to address the weight loss.

Good

Is the service caring?

Our findings

One person told us, “The staff are good but they are always running around doing something.” A visitor said, “The girls are good here.” One member of staff told us, “I feel I’m working with my Mum and Dad and that’s how I treat them [people using the service]. Staff work well as a team.” Another said, “The people here are important to me.” One professional said that staff did their best.

Care was delivered by staff in a patient, friendly and sensitive manner. We observed and listened to interactions between people and staff throughout the duration of our inspection. There were occasions when staff were unaware we were observing them. We found the interactions between people and staff were mainly positive, occasionally neutral and none of the interactions we saw or heard were negative. We saw one member of staff accompanying one person into the lounge. Their arms were linked, they were walking quite slowly and the member of staff was speaking to them quietly as they walked along. The person was smiling. People were referred to by their preferred from of address which in most cases was by their first name. Staff bent down to speak to people if they were sitting down. People were not rushed when eating their lunch. We saw one member of staff encouraging one person to eat some more of their lunch. When carrying out tasks we heard staff explaining to people what they were going to do. Visits from relatives were encouraged and there were no restrictions on visiting times.

People and appropriate relatives or representatives were involved in planning their care and there was evidence of that in care plans and our conversations with relatives. People’s choices and preferences were recorded. These included straightforward things such as what they liked to wear, their preferred bathing routine and on a more individual basis one person liked to have one glass of brandy every night.

Staff respected people’s privacy and dignity. Staff knocked on people’s bedroom doors before entering. Personal care was delivered in private away from and out of sight of other people. We talked with people on each day of the inspection. We saw that they were appropriately dressed in clean clothes. The men were clean shaven. Their hair was clean and we did not notice any malodours around people. We visited one person in their room They were comfortable, clean and well dressed. One relative said, “Never been an occasion when [my relative] was not clean.” Another relative told us, “I must say her clothes are clean on every day.”

The service had been working with a local hospice to develop their end of life care. We spoke with a representative from the hospice who told us that ‘Do not attempt cardiopulmonary resuscitation’ forms (commonly known as DNARs) were in place for people with the involvement of the GP and families. The hospice was still working with the service in relation to end of life care with staff training yet to be fully completed.

Requires improvement

Is the service responsive?

Our findings

The service was not always responsive. 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 about how care and treatment met their needs. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The building of the extension had resulted in the manager's office being moved from the first floor to the ground floor by the new entrance to the building. This made the manager more accessible. People using the service told us they would raise any issues they had with a member of staff. Relatives of people told us the manager was approachable and usually if they had an issue it would be dealt with. One relative told us, "We usually get a response if we complain about something, eventually it gets fixed." Since our previous inspection the manager said they had not recorded any formal complaints. There was a system in place for recording and addressing complaints. There was also a complaints and compliments book in the foyer of the building.

We looked at the care records for people. They were person centred and identified a range of people's social and healthcare needs. They provided guidance to support staff with the delivery of safe and effective care. The service had introduced new care plans since our previous inspection which were easier to read. People were encouraged to maintain as much independence as possible by carrying out daily tasks where they were able such as personal care.

There was very little in the way of organised activities for people using the service. One relative told us, "Whenever I go in I could tell you exactly where [my relative] would be – in the same place every time doing nothing." Another relative commented, "I've been there lots of times but I've never seen any activities. They don't really sit and talk with them."

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. One of the afternoons of our inspection coincided with the activities coordinator. The planned activity, which involved catching and throwing, took place among a small group of people in the lounge who did not look interested. Most people sat somewhere in the lounge and conservatory area. There was a larger TV in the largest part of the lounge that was switched on throughout the day. Around the corner there was another TV that was switched on and watched by one person when they were awake. Whether it was before or after lunch people sat in the lounge facing the TV where three to four people were usually asleep. There was a church service in the lounge every second Tuesday afternoon in the month and one took place during our inspection. There was a selection of films, games, jigsaw puzzles and music available but they were not used during the inspection. The manager told us bingo was the favourite activity. People also liked black and white films and music. We were told that once the weather improved people would be able to sit on the decking platforms.

Requires improvement

Is the service well-led?

Our findings

The service was not always well-led. The provider should have had effective systems in place to make sure the quality of service they provided was regularly monitored and assessed to prevent inappropriate or unsafe care. In this report we have seen failings around pressure ulcer care, staff training and seeking the views and experiences of people using the service that shows the systems in place were not effective. There were a number of internal audits and reviews carried out by the manager to monitor and assess the quality of service provided. These included for example, reviews and audits of care plans, risk assessments, fire safety and medicines. 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. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found that staff meetings took place every month and we saw that there were minutes for the meetings. At this inspection one member of staff said, “We haven’t had a staff meeting for months.” Staff had been told there would be a meeting with the provider in the near future. We asked the manager to send us minutes of the last staff meeting. We were sent a copy of minutes of a staff meeting which was undated. As it started off thanking staff for attending the Christmas party it would appear it was for a meeting sometime in December or January. The minutes recorded subject areas such as standards of care, uniforms, handovers, laundry and meals. The minutes read like instructions to staff and there was no record of staff feedback suggestions or contributions to discussions.

The manager was very visible throughout the service. People using the service and visiting relatives regularly saw the manager outside of the office helping staff. The manager regularly helped out at lunchtimes. Staff had regular contact with the manager and there was informal feedback from staff on a day to day basis. When we spoke with relatives they all said they could speak to the manager if they had any issues and wanted to feedback about their experiences or the experiences of their relatives living at the service. Representatives of the provider were also regularly seen 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 have staff with sufficient skills and knowledge about the prevention, recognition and planning of safe care for people at risk of pressure ulcers and did not mitigate the risks identified by relevant risk assessments. Regulation 12(2)(a) and (b).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider did not provide staff with appropriate support and training to carry out their duties. Regulation 18(2).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider did not have systems in place to actively seek the views and experiences of people using the service and their representatives. Regulation 9(3)(f).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not effectively assess, monitor and improve services provided to people. Regulation 17(2)(a) and (b).**