Ashberry Healthcare Limited

Moorhouse Nursing Home

Inspection report

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Date of inspection visit:
15 November 2018

Date of publication:
14 January 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an unannounced focused inspection of Moorhouse Nursing Home on 15 November 2018. This inspection was done as we had received concerns about staffing levels, how risks to people were managed and the lack of management oversight at the service. The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well led?

No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

Moorhouse Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Moorhouse Nursing Home accommodates up to 38 older people, some of whom may be living with a physical disability, in one adapted building. At the time of our inspection there were 26 people using the service.

At the time of the inspection there was not a registered manager in post. The manager who was present was leaving and a new manager, who was also present, had been appointed three days previously. The new manager told us they would be applying to register with CQC as manager in line with the requirements of their registration. 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.

There were not enough staff to meet people's needs which left them waiting for care to be delivered. Risks to people were not always managed effectively which placed people at risk of harm. Where incidents and accidents occurred, these were not analysed to reduce the risk of them re-occurring. There had been a high turnover of managers in the last six months which had affected the care being delivered to people. There was a lack of management oversight and audits on the quality of care were not being completed. Staff did not feel listened to when they raised concerns about staffing levels. We asked for information about how the service acted with external agencies but this was not provided.

People received their medicines when they needed them. The management of medicines was safe. People were kept safe from the risk of abuse as staff knew what to do should they have concerns about the standard of care provided. There were safe infection control practices in place which staff followed. The environment was clean and well maintained and safe recruitment procedures were in place.

We identified two breaches of the Health and Social Care Act 2008 (HSCA). You can see what action we asked the provider to take at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not enough staff to meet people's needs. People were sometimes having to wait for care to be provided as a result. However staff were recruited safely.

There was an inconsistent approach to risk management which meant people were not always kept safe. Opportunities to learn lessons from accidents and incidents were missed as these were not analysed to prevent a re-occurrence.

Medicines were managed safely.

Staff understood their responsibilities to safeguard people from harm.

People were protected from the spread of infection and the environment was clean.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There had been a number of changes in management which had led to lack of direction and leadership for the service.

There had been no effective monitoring of the service by the manager or provider which impacted on the care being given.

There was no evidence of how the service engaged with people or those important to them to help improve the quality of care provided.

Moorhouse Nursing Home

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.

The inspection was prompted in part by concerns that were raised about staffing levels, how risks and medicines were managed and a lack of management oversight.

This inspection took place on 15 November 2018 and was unannounced.

The inspection was carried out by two inspectors, a specialist nurse advisor 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.

Prior to the inspection we reviewed the information we held about the service such as notifications that had been submitted. Notifications are changes, events and incidents that the service must inform us about. The provider did not send us a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. This was because we had brought the inspection forward due to the concerns that had been raised with us.

During the inspection we spoke with 12 people and four relatives. We spent time observing interactions between people and the staff. We spoke with seven care staff including the nurse on duty and chef. We also spoke with the manager who was leaving and the manager who was newly appointed.

We looked at four people's care plans including their personal risk assessments and medicines charts. We checked that what was detailed in these plans matched the support and care that people received. We also checked three staff recruitment files.

We checked whether mandatory policies and procedures were up to date and in place. We reviewed the

recording of accidents and incidents in the home, call bell response times and staffing rotas. We looked at documentation in relation to how the safety and quality of the service was monitored to understand how well the service was being governed and managed.

Following the inspection we asked the new manager to send us information in respect of staffing levels and quality assurance records, which they did.

Requires Improvement

Is the service safe?

Our findings

Prior to the inspection concerns had been raised about the lack of staff which we found was the case. People and relatives told us there were not enough staff to meet people's needs. One person told us, "They [staff] take a rather long time to answer the bell. It means I have to wait." Another told us, "There are not enough staff. The other night they had two [staff] to run the entire night shift, if someone had hurt themselves they would have been in a terrible position." One relative told us, "There are probably not enough staff here as it takes a long time for people to answer the buzzer," whilst another said, "There are not enough staff. It means they are late to help."

The manager told us that there should be one nurse and five care staff working during the day and one nurse and three care staff at night. This was based on the service's dependency tool that was used to determine safe staffing levels. The manager told us that the dependency tool had not been reviewed since August 2018 which meant that they could not be certain that the correct number of staff were being deployed. People's rooms were on two floors, the ground floor had an annex which was a long walk from the communal area. The dependency tool did not consider the layout of the building.

We reviewed the staffing rota for the preceding four weeks and found that there were 25 occasions during the day when these staffing levels were not met. For the same period there were 27 occasions when the staffing levels at night fell below what was needed. Staff told us they were struggling to meet people's needs as a result and this led to people waiting for care to be provided. One member of staff told us, "We are really struggling to get things done," another said, "We don't have enough time to complete our work."

People and relatives said the lack of staff meant that call bells were not always answered promptly. There had been 43 occasions in the previous two weeks where call bells took more than 10 minutes to be answered. Throughout the day we saw that staff were very busy attending to people. One person needed to be repositioned regularly and asked to be moved. Staff told them they would be 10 to 15 minutes as they were busy helping other people. Other people had to wait for drinks to be provided and we found some people who were still in bed were waiting to have personal care given. When we arrived, the nurse was undertaking the medicines round which finished at 11.15am. The next medicines round was due to start at 12pm which meant the nurse did not have time to attend to other nursing tasks such as wound care management or speaking with visiting healthcare professionals.

Failure to ensure sufficient numbers of staff were employed to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the new manager contacted us to say that care staff levels had been increased whilst people's dependencies were re-assessed.

There was an inconsistent approach to managing risks to people. The risk assessments seen were reviewed regularly however action was not always taken when changes were identified. One person was approaching the end of their life however there had been no care plan introduced that reflected this or managed the risk

to them. For example the person required their fluid intake to be monitored but this was not considered and no record made of this. The contents of the first aid box were not complete and contained items such as adhesive dressings and plasters, that were out of date.

People were at risk as accidents and incidents were not analysed to look for patterns or trends. This meant the opportunity to learn from these was missed. The reports we saw did not give details about what had happened in respect of each incident, what the outcome was or what had been done to prevent a re-occurrence. The forms themselves required them to be reviewed and signed by the manager. This had not been done.

Failure to consistently manage risks to people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Another person had been admitted to the service following a number of falls. Staff told us about the steps they took to support this person when mobilising. The person's care plan had clear guidelines in place for staff to follow to help keep them safe. People received practical support from staff when moving and had walking frames where needed. These risks were reviewed regularly and changes made when people's needs changed.

Some people were nursed in bed and at risk of developing pressure sores. This required them to be turned regularly. Staff knew the risks for those people who were immobile and took steps to reduce the risk of pressure damage. Pressure relieving equipment was in place for those who needed it. Other risks such as choking were identified and advice sought from the appropriate healthcare professionals.

People were supported to take their medicines safely. One person told us "My medication comes regularly." A relative told us "[Person] gets [their] medication and I am advised if there is a change in [person's] drugs."

We observed the medicines round and saw that the nurse followed safe medicines practice. Each person was asked if they were happy to take their medicines and when they had this was recorded on an electronic medicines system which staff were trained in. This system was audited regularly.

Medicines records contained photographs of people and listed their allergies. Protocols were in place to support the administration of 'as needed' (or PRN) medicines and these were in the process of being reviewed and updated. Medicines were delivered and disposed of by an external provider and stored safely within the service. Medicines rooms were locked with temperatures recorded. Fridges also had a daily check recorded.

Safe recruitment practice was used prior to staff starting work. Staff recruitment files contained application forms and references from past employers. Evidence was also available to show that Disclosure and Barring System (DBS) checks had been completed. DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. Staff we spoke to also confirmed that they had undergone recruitment checks prior to starting work at the service.

People lived in an environment that was clean which protected them the spread of infection. Staff understood the need to use personal protective equipment (PPE), such as aprons and gloves, and to ensure they washed their hands before and after care was delivered. People's rooms were clean and tidy. Cleaning staff maintained a good standard of cleanliness throughout the home and in communal areas and bathrooms. One relative told us, "I'm happy with the cleanliness."

People were safeguarded from abuse. Staff had been trained in safeguarding and were aware how to raise any concerns. They said they would speak to the manager or the local authority if necessary. There was a safeguarding policy in place for staff to refer to if needed. Safeguarding concerns had been appropriately reported to both the local authority and CQC.

Requires Improvement

Is the service well-led?

Our findings

There was a lack of oversight and leadership in the service which affected the confidence people had in receiving good care. People and relatives told us there had been a number of management changes in the last six months which had left them feeling unsettled. One person told us, "The manager has barely been here and we have another one starting now", another person said they had concerns about the suitability of the manager who was now leaving. A relative told us the quality of care had gone "Downhill".

Staff also told us that the management of the service was not effective and this had a negative impact on them. On member of staff told us, "We've tried to say things [about staffing levels] but they don't listen. We back each other rather than management because we don't feel anything will be done."

The provider had recruited a new manager who had started working at the service three days prior to our inspection. They had identified that audits on the quality of the service had not been completed since the registered manager had left in May 2018. We asked for audits on the quality of the service to be sent to us after the inspection. We were sent an undated service development plan which highlighted that audits should be completed in fire safety, infection control, health and safety, catering and pressure care. Medicines audits were also not being completed.

The manager told us that call bell audits were completed to ensure that the call bell system was working. This was also mentioned in the service development plan we were sent. However there had been no analysis of the call bell response times completed to ensure people always received care in a timely way. From our review of the call bell records we identified that one person used their call bell at similar times each morning and was consistently waiting longer than 10 minutes to be responded to by staff. This was a pattern that could have been identified if analysis had been completed. There had been no oversight of people's dependencies since August 2018 which meant that the staffing levels in place may not have been correct.

Following concerns being raised with CQC we approached the provider before we inspected to seek assurances that people were receiving safe care and treatment. As a result the provider had undertaken a quality monitoring visit at the beginning of November 2018. However this had not identified the concerns we found on the inspection in relation to call bell response times and of staffing levels, despite staff raising concerns about staffing levels with the provider's representative at the time. It had identified that the outgoing manager had not been monitoring the service appropriately however this information was not shared with CQC at the time.

There had been a staff meeting in October 2018 but staffing levels were not discussed. Staff told us they had raised the lack of staff with the manager but this had not been acted upon. Staff also told us they were not having regular one to one discussions and had raised issues about the lack of activities but again told us this had not been addressed or attempts made to understand why this was an issue.

Failure to monitor the safety and quality of the service and maintain oversight was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection we asked the new manager to send us information on how the service worked with outside agencies and information on any residents and relatives' meetings however these were not sent to us. The provider will be responsible for sending us an action plan following this report to show how and by when they will make the required improvements.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was an inconsistent approach to managing risks to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were not effective.

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 There were not enough staff to safely meet people's needs.