Four Seasons (No 10) Limited

Murrayfield Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 17 and 18 November 2014 and was unannounced. At our last inspection in February 2014 the service was meeting all the regulations we looked at.

Murrayfield Care Home provides accommodation, nursing and personal care for up to 74 older people over three floors. The second floor supports people with dementia.

The registered manager left the service in July 2014 and resigned in December 2014. An interim manager was managing the service until a new manager was appointed. 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 and associated Regulations about how the service is run.

The home had not been managed effectively since the registered manager's recent resignation and the appointment of an interim manager. There had been a high number of safeguarding alerts during this period which had caused concern to the Care Quality Commission (CQC) and the local authority safeguarding

Summary of findings

team. As a result, the local authority had developed an improvement plan for the organisation at the time of the registered manager's resignation and regular meetings were being held to monitor the standard and safety of the service.

The management of medicines at the home was not being managed safely and people were being placed at unnecessary risk. Although the service was auditing medicines, problems and risks to people's safety were not being identified.

Although staff understood the principles of the Mental Capacity Act (MCA 2005) this was not reflected in people's care plans and some people did not have the required safeguards in place so their deprivation of liberty could not be monitored and reviewed.

People were not positive about the food provided. There were not always choices on the menu and the quality of food was not of an acceptable standard, particularly for those people who required their food to be pureed because they had swallowing problems.

People we spoke with and their relatives expressed concerns about staff and staffing levels. We saw that the interim manager had increased staffing levels since she was in post. Some relatives said that staff did not always communicate effectively with them but the majority of people told us that staff treated them with kindness and respected their privacy and dignity.

We saw examples where nursing staff had managed people's clinical needs very well, particularly in relation to pressure care and wound care. However, people's assessed needs were not always being met properly and in some cases we found that people had been admitted to the service when they should not have been because the service could not meet their assessed needs safely.

Some relatives we spoke with did not have confidence in the provider's ability to improve or sustain any improvement. They told us that the service had a history of problems and then making improvements but these had not been sustained. The interim manager was aware of this lack of trust in the provider and had introduced a number of systems to improve the service but acknowledged it would take time to regain people's trust.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These breaches were in relation to medicines management, consent to care, nutrition, assessment and welfare, quality assurance and health and safety monitoring. You can see what action we told the provider to take at the back of the full version of the report.

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?

Inadequate

The service was not safe because the service was not managing medicines properly and this was putting people at risk.

People told us they were concerned about staffing levels and we saw that the interim manager had taken steps to ensure staff vacancies were covered by agency or bank staff.

Staff were properly recruited to make sure only suitable staff were employed at the home.

Is the service effective?

Inadequate

The service was not effective as the provision of meals was inadequate both in terms of choice and quality.

Although people told us, and records showed, that people had good access to healthcare professionals such as dentists, chiropodist and opticians, there were on going problems with accessing a GP service. This was having a negative effect on people as there were a high number of visits to the local Accident and Emergency department.

The service was not always following the requirements of the Mental Capacity Act (MCA) 2005 including the Deprivation of Liberty Safeguards (DoLS) as the need to keep some people safe in the home was not being reviewed or monitored.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring as not everyone was as involved in their care planning as they wanted to be.

People told us that staff were kind and respected their dignity and privacy.

We observed staff treating people with respect and as individuals with different needs and preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive. In some cases we found that people had been admitted to the home when their assessed needs could not be met by the staff.

We saw that there was some good care being provided but this was not always consistent with people's assessed needs.

Although people who used the service and their relatives knew how to make a complaint, not everyone was confident their complaint would be properly addressed by the management.

Summary of findings

Is the service well-led?

Aspects of the service were not well-led as the management had been inconsistent and people and their relatives had lost confidence in the organisation's ability to improve and to sustain any improvement.

Staff were positive about the interim manager and told us she was approachable and open to comments and suggestions they made.

Quality assurance systems and assessments of risks were inconsistent and not always effective which was putting people at unnecessary risk.

Inadequate

Murrayfield Care 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 checked 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 unannounced and the team consisted of three inspectors, a specialist advisor and a pharmacist inspector. The specialist advisor was a qualified nurse and helped us to check care planning, nutrition and pressure care management.

Before our inspection we reviewed information we held about the provider, including notifications of abuse and incidents affecting people's safety and wellbeing. We also spoke with the local safeguarding team manager, local commissioning manager, and other healthcare professionals who were visiting Murrayfield Care Home on the day of the inspection.

We spoke with 16 people who used the service and six relatives and friends of people using the service so they could give their views about the home.

Some people could not let us know what they thought about the home because they could not always communicate with us verbally. We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to check that the way staff spoke and interacted with people had a positive effect on their wellbeing.

We spoke with 12 staff as well as the interim manager and the regional manager.

We looked at 15 people's care plans and other documents relating to their care including risk assessments and medicines records. We looked at other records held at the home including health and safety documents and quality audits.

Inadequate

Is the service safe?

Our findings

People told us they felt safe. However, relatives had mixed views about people's safety. Two of the six relatives we spoke with were concerned about the security of the building as well as staffing levels. We also found that people had been placed at risk because they did not always receive their medicines as prescribed.

On two of the three units, we saw evidence that people were receiving their medicines as prescribed. On the ground floor, we looked at medicines records for 11 people and saw that there were gaps and discrepancies on all records. Therefore it was not possible to confirm that people had received their medicines as prescribed.

Four people had not received their medicines as often as prescribed, including pain relieving tablets, patches and creams, which placed these people at risk of not receiving adequate pain relief. Some people were prescribed medicines to be given only when needed, such as pain relieving medicines and medicines for reducing anxiety. Their medicines and care records did not contain sufficient instructions on when to administer these medicines. For example, one person was prescribed a sedating medicine to be given only when needed, and two members of staff on duty on the day of our inspection gave us different explanations about when they would administer this medicine.

Where people were prescribed medicines with a variable dosage, such as one to two tablets at each dose, in most cases, staff were not recording exactly how many tablets they were administering at each dose. The dose of insulin to be administered to one person had not been recorded clearly, placing this person at risk of receiving this medicine incorrectly. If the entries made on the medicines records were correct, three people had been given double doses of their medicines in error, which placed these people at risk of overdose. One person was keeping and self-administered prescribed food supplements, this had not been risk assessed to check whether the person was able to do this safely.

The interim manager told us that a system was in place to audit the management of medicines, however because of the issues we found, these audits were not always effective in picking up and addressing issues with the management of medicines. On the second day of the inspection a further audit of medicines was undertaken by the provider.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People who used the service and some relatives we spoke with had concerns about the staffing levels at the home. One person told us, "The staff are so good [but] they are short staffed," another person told us that there were, "not enough staff." A relative commented, "Some staff are nice but there are never enough staff. It is understaffed I think. Staff are always rushing."

The interim manager told us that staffing was an issue as there were care staff and nursing staff vacancies at the home. The manager said that these vacant posts were being advertised and until then the staffing numbers were being maintained by bank and agency staff. We saw that staffing levels on the day of this unannounced inspection matched the number of staff that should be working at the home as detailed on the staff rota. Staff told us that the staffing levels had improved since the interim manager had started at the home.

Staff could explain how they would recognise and report abuse. They told us that they received regular training in safeguarding adults. Staff understood how to "whistle blow" and were also aware that they could report any concerns to outside organisations such as the police or the local authority.

Since June 2014 the Care Quality Commission (CQC) had received notification of 20 safeguarding alerts. As a result of this high number of alerts, the local safeguarding team had been working closely with other health and social care professionals to investigate the concerns and to implement an improvement plan. The CQC has been in regular contact with the local safeguarding team to monitor the safety and wellbeing of the people living at Murrayfield Care Home. As a result of these safeguarding concerns the provider put a voluntary suspension on admissions to the home.

We saw that risk assessments and checks regarding the safety and security of the premises were up to date and being reviewed. These included the fire risk assessment, monitoring water temperatures to reduce the risk of scalding and checks to reduce the spread of water borne infections such as Legionella.

Inadequate

Is the service safe?

The care plans we reviewed included relevant risk assessments, such as the Malnutrition Universal Screening Tool (MUST) risk assessment, used to assess people with a history of weight loss or poor appetite. Pressure ulcer risk assessments included the use of the Waterlow scoring tool and falls risk assessment. These tools were recommended by the National Institute for Clinical and Healthcare Excellence (NICE).

We checked staff files to see if the service was following robust recruitment procedures to make sure that only suitable staff were employed at the home. Recruitment files contained the necessary documentation including references, people's employment history, right to work in the UK, criminal record checks and information about the experience and skills of the individual. Staff told us that they were not allowed to work until the service had received their criminal record checks and references.

Inadequate

Is the service effective?

Our findings

There were mixed views about whether staff had the necessary skills and knowledge to look after people properly. One person commented, "The staff are good. They help me." A relative told us, "Generally the care staff are all ok. No issues. They are helpful and always answer my questions." But one person we spoke with told us that the staff, "treat me like a five year old."

Staff understood the principles of the Mental Capacity Act 2005 (MCA) and, with one exception; we observed staff asking people for permission before carrying out any required tasks for them. We saw one member of staff not communicating with the person they were supporting. The staff member adjusted the person's clothing and moved them without letting them know what they were doing which had a negative effect on that person's wellbeing. We told the interim manager about this so they could take action. However, this was the only time we saw a negative interaction between staff and people they were supporting.

Capacity to make specific decisions was not always being accurately recorded in people's care plans and we saw blanket statements about people's capacity rather than consideration of specific decisions they needed to make.

We also found that, where people were unable to leave the home because they would not be safe leaving on their own, the home had not applied for the relevant safeguarding authorisations called Deprivation of Liberty Safeguards (DoLS). These safeguards ensure that an individual being deprived of their liberty, either through not being allowed to leave the home or by using a key pad which they would not be able to use, is monitored and the reasons why they are being restricted is regularly reviewed to make sure it is still in the person's best interests.

This was not happening in the home and therefore some people's fundamental rights were not being respected.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not positive about the food provided and the interim manager acknowledged that the quality of food provided at the home was not up to an acceptable standard. People's comments about the food included, "The food is OK but not to my liking," "Food is terrible," and "You used to get a choice of food but you don't now." Relatives commented, "Food is not good, there is no choice," and "The food is ok. My mum says some days are good and some days the food is not so good. Hit and miss."

On the first day of the inspection there were two choices of menu for lunch, beef stew or grilled fish. However no one was given the grilled fish, which looked unappetising and was not attractively presented. A number of people at the home had health conditions that made swallowing difficult for them and their meals had to be pureed so it was easier and safer to swallow. We saw that there was no choice of pureed meals and a relative told us, "My relative has puree food; everyday it is the same, always mashed potatoes, meat and vegetables. They don't get to choose."

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed people having their lunch, which was unhurried. We observed staff were respectful and assisted each person who needed help with their meals. People were assisted in a dignified way and we noted people had been offered a selection of soft drinks at mealtimes and in between meals.

The care plans we checked showed regular risk assessments using MUST to monitor people's nutritional needs. We reviewed the care plan on nutritional needs for a person with a history of choking and swallowing problems. The form showed the person was at risk of weight loss, choking, aspiration and nutritional imbalance. Appropriate risk assessments had been carried out, for choking and for malnutrition using MUST. We saw information indicating the speech and language therapist (SALT) and the Nutritional and Diabetic Service had been involved in the person's care and treatment.

We saw records of people's daily food intake, fluid intake and output charts, which had been filled in correctly, with the last entries on the day of inspection. We were told these records had been kept for people who had poor appetite or weight loss.

We observed a member of staff assisting the person in their bedroom at lunchtime. The person was given drinks mixed with thickener because the person had problems swallowing. All the food and drinks they had taken were

Inadequate

Is the service effective?

later documented on the food and fluid chart kept in their bedroom. We noted the person's monthly weight chart and their daily food intake and fluid chart had been correctly filled in and had been kept up to date.

Staff told us that the organisation provided a good level of training in the areas they needed in order to support people effectively. This training included equality and diversity, first aid, infection control, food hygiene and moving and handling. Staff told us the training had increased their understanding and confidence in these key areas. They told us training opportunities had improved since the interim manager took over and there were now more face to face training sessions rather than just having e-learning on a computer. We saw training certificates in staff files which confirmed the organisation had a mandatory training programme and staff told us they attended refresher training as required. We met with the training manager for the organisation who showed us records that staff had completed the majority of this training and that refresher training had also been booked.

Staff confirmed they received supervision and appraisals from their line manager but told us this was not always happening on a regular basis. They told us this was a good opportunity to discuss how their work was going and look at any improvements they could make.

In people's care plans we saw evidence of people being seen by other healthcare professionals, including speech and language therapists, physiotherapists and dieticians when required.

People and their relatives said they had good access to other healthcare professionals such as dentists, chiropodists and opticians. However there was concern expressed by both relatives and staff concerning the difficulty people had in accessing a GP service. We spoke with the community matron who visited the home on a regular basis to give advice and support. They told us there were high numbers of people being taken to the local Accident and Emergency department. They told us this was, in part, due to the lack of GP support to the home. We were informed that the local Clinical Commissioning Group were aware of the problems and were trying to find a solution.

Requires Improvement

Is the service caring?

Our findings

People told us they did not always feel involved in making decisions about their care although some people said they were happy that the service dealt with and managed their care needs. We asked one person if they had access to their plan of care. They told us, “I’ve never seen it but I’d like to. I’d like to know what they are doing.” Although some care plans we looked at had been signed by the person who used the service we did not see any further written evidence in plans to indicate any more personal involvement.

People told us that staff were kind and listened to what they had to say. One person commented, “The staff are quite nice. They are caring.” Other comments about staff included, "I like it here. The staff are very good,” and “They look after me wonderful.” A relative told us, “Staff are friendly, respectful and always listen.”

Staff understood that people’s diversity was important and something that needed to be upheld and valued. They gave us examples of how they respected peoples’ diverse needs in terms of people’s culture, religion and gender. Staff told us they undertook practical sessions where they experienced what it was like to have a disability. For example, a staff member would be blindfolded and helped to eat to gain an understanding of what this experience was like for people with sight problems. Staff told us this was a very powerful experience.

We observed staff respecting people’s privacy through knocking on people’s bedroom doors before entering and by asking about any care needs in a quiet manner and without being overheard by anyone else. Staff were able to give us examples of how they maintained people’s dignity and privacy not just in relation to personal care but also in relation to sharing personal information.

We recommend that the service seek advice and guidance from a reputable source, about supporting people to express their views and involving them in decisions about their care, treatment and support.

Requires Improvement

Is the service responsive?

Our findings

We saw handwritten pre-admission assessments in each of the care plans we checked. The pre-admission notes included the person's medical history, healthcare needs and the assistance they required.

Prior to this inspection we spoke with the local authority safeguarding and commissioning team. They told us that they were concerned that the service was admitting some people with complex mental health needs which staff at the service were unable to meet. Because of this they had written to all placing authorities and requested that these people's placement at the service be reviewed.

We met with one person who was clearly distressed and who was calling out constantly throughout the day. We asked staff what they were doing to support this person. Staff told us they did not know why this person was shouting and told us the GP had prescribed medicine to calm the person. However there was no written indication when this medicine should be given and no behavioural plan was in place to help staff monitor the person's behaviour or look for possible reasons why this person was calling out.

We met with another person who had behaviours that challenged the service. Staff told us that this person's behaviour was very unpredictable and other, frailer people were at risk. Because of this we saw that a staff member had been allocated to support this person on a one to one basis. However, staff told us they had been hit by this person and that they were nervous of them because of the risk they posed to themselves and people using the service.

We noted the written care plans in use were in the form of a series of pre-printed booklets covering different aspects of the person's needs. For example, section one dealt with rights, consent and capacity needs. Section two dealt with drug therapy and medicine needs and section four dealt with nutritional needs. Each booklet included relevant risk assessments and the written care plan. It detailed the care to be provided and included monthly reviews of care needs and updates to the care plan as needs changed. The care plans we reviewed indicated people's care needs had been regularly assessed and any changes in their care needs had been documented.

However, we found the care plan booklets were not user-friendly and the written contents lacked detail. For example, in the case of a person on the first floor who had dementia, there was no specific care plan on the person's condition and no action plan to direct staff on how to care for this aspect of the person's needs. The only section where dementia was mentioned was in the booklet which was about rights, consent and capacity. The unit manager confirmed there was no care plan section specifically for dementia.

Inappropriate needs assessments and subsequent admissions were putting people at risk of receiving care and treatment that was inappropriate and unsafe. The lack of specific information and instructions to guide staff how to care for people also meant people were exposed to the risk of receiving inappropriate care and treatment.

These issues were a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2010.

Nursing staff were working hard to meet the clinical needs of people at the home in terms of wound care. For example, we noted that staff were following appropriate clinical procedures in line with NICE guidelines and therefore people's leg ulcers and pressure ulcers were improving. It was of particular note that two people who had the most severe grade of wound (grade 4) were assisted to be almost healed and that the local tissue viability nurse (TVN) had discharged these people from her care as a result. The community matron confirmed that staff were doing well in this area of clinical care.

We were told the service had activities six days a week. There were three activity workers, who worked from Monday to Friday and who took it in turns to work on Saturday. Other staff also helped with activities.

We observed a cookery session in progress on the first day of the inspection. There were 17 people sitting at a long table. The activity worker placed bowls of ingredients on the table and explained to people what they were. The chef explained and demonstrated how to mix and stir the mixture. The activity worker and two other care workers gave individual attention to people and interacted well with them.

We observed other members of staff interact with those people who did not want to join in the activity. We were told that people were free to choose activities held on floors other than their own and some of the people present were from other floors. We saw a number of activities taking place however, some relatives we spoke with did not

Requires Improvement

Is the service responsive?

feel there was enough of a variety of activities going on. Relatives commented, “My relative plays bingo there but I have not seen activities taking place when I have been there,” and “I haven’t seen many activities.” One person told us, “You’ve nothing to do.” The interim manager told us that activities had increased at the home however this increase had only happened relatively recently and the activity workers were still consulting people for their suggestions and preferences.

The activity worker showed us the weekly activity programme, which, however, did not reflect the cookery activity that we had just observed. Another member of staff said, “Under the new interim manager, the activities have increased. We haven’t updated the activity chart yet.” One person told us, “We had a singer last Wednesday and they were marvellous.”

People who used the service and their relatives knew how to make a complaint or raise a concern. One person we spoke with had made a complaint and told us, “It’s all been seen to.” A relative commented, “I feel able to complain if I need to the nurses or management.”

We looked at the complaints records and saw there was one outstanding complaint which was still being investigated. Records showed that the organisation’s complaints policy was being followed appropriately.

However three relatives we spoke with told us they did not feel making a complaint would lead to any improvement. One relative said, “What’s the point?” Another relative told us that sometimes staff became defensive when they raised concerns.

The interim manager was aware that relatives did not always feel they were listened to and, as a result, had implemented regular surgeries where relatives could meet with her to discuss any concerns.

Inadequate

Is the service well-led?

Our findings

Quality monitoring systems and safety audits were not always effective or robust enough to identify problems within the service. For example, the medicine audits had not picked up the serious issues on the ground floor. We were informed that a yearly quality survey was sent out to people and their relatives in order that they could comment on the quality of the service provision. However no survey had been sent out this year.

This was a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2010.

The registered manager had left the service in July 2014 and later resigned in December 2014. This had caused concern for both people using the service and their relatives. People told us they had not been informed why this had happened and felt the standard of care had dropped since the registered manager had left. One relative told us, "It's got worse."

The interim manager and the regional manager were aware that some relatives had lost trust in the organisation; firstly that improvements would be made and secondly that these improvements would be sustained. A relative told us, "I've got no confidence in the management whatsoever."

Relatives told us about previous meetings held at the home but said they had not received any feedback, minutes of these meetings or any action plans arising from their comments or suggestions. One relative told us, "there has been a breakdown in communication."

We were also concerned about the management of the service as the local authority had raised concerns about people being inappropriately placed at the home. We saw examples of people's needs not being properly assessed or met during this inspection.

Both the interim manager and regional manager were clear about the recent failings of the service and told us they were very committed to improving the standards at Murrayfield. The interim manager had implemented a number of systems to improve the service in line with the improvement plan developed by the local authority safeguarding team.

Staff were positive about the interim manager and the changes that had already been made. These changes included improved staffing levels to match the staffing rota, increased activities and recruitment to vacant posts.

Staff told us the interim manager was approachable and open to comments and suggestions they made. One relative told us, "The new manager is helpful and talks to us and answers questions."

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 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Service users were not protected from the risks of unsafe use and management of medicines, because some service users were not receiving their medicines as prescribed and records of medicines given to service users were not always clear or accurate.** **Regulation 13 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **Service user's fundamental rights were not always being protected as the registered person was not following the requirements of the Mental Capacity Act 2005 and some service users were being deprived of their liberty without appropriate safeguards being in place.** **Regulation 18**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **Service users were not being protected from the risk of receiving inadequate nutrition and hydration.** **Regulation 14 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Treatment of disease, disorder or injury	Service users were being put at risk of receiving unsafe care or treatment because needs assessments of service users were inconsistent. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Service users were at risk because the service did not have effective systems in place to monitor the quality and safety of service provision. Regulation 10 (1) (2)