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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Morven House is a residential care home providing personal care to up to 40 people. The service provides support to older people requiring residential support. The service does not provide nursing care. At the time of our inspection there were 26 people using the service.

People's experience of using this service and what we found
People were not always protected by the provider's planning and safety checks. The service had not updated its fire evacuation plan as directed by fire services and failed to deploy enough staff over night to be able to implement the evacuation plans in place. Daily health and safety checks failed to detect hazards we found which included risks of tripping and falling from height.

People's individual risk assessments did not always contain enough information to support staff to mitigate risks. Checks were not made of the temperatures at which medicines were stored and we found the temperatures on both medicines' trollies exceeded permitted levels.

The service did not have a registered manager in post. The new manager had been in post for only 2 weeks at the time of our inspection. People, relatives and staff expressed confidence in the new manager and noted a number of improvements they had made already.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The care home was clean. Staff followed an enhanced cleaning programme and wore appropriate personal protective equipment to reduce people's risks and spread of infection. Food was stored and prepared safely, and good hygiene practices were followed in the laundering of clothing and bedding.

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 requires improvement (published 12 May 2022). The service remains rated requires improvement. This service has been rated requires improvement for the last three consecutive inspections.

Why we inspected
This inspection was prompted in part due to concerns received about fire safety, staffing, medicines and the management at the service. 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 the safe and well-led sections of this full report. The provider has taken action to mitigate the risks we found.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Morven House on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to people's safe care and treatment and the provider's leadership of the service.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We have requested further action plans from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Morven House

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by 2 inspectors.

Service and service type
Morven House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Morven House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection the registered manager was not in post having left the service. However, they had not yet de-registered with CQC.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with 5 people, 1 relative, 4 staff, the new manager and 2 directors. We reviewed 6 people's care record and 4 staff files. We undertook checks of the environment and people's medicines, and we reviewed the provider's fire safety and quality monitoring processes.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained 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
At our last inspection in January and April 2022 and at the inspection before it in June 2021, the provider had failed to ensure people were protected from the risk of unsafe care. This was a breach of part of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Sufficient improvement had not been made at this inspection and the provider remained in breach of regulation 12.
● People's safety in the event of a fire emergency could not be assured. The provider failed to review, update and improve the service's emergency evacuation procedure in line with the directions of the fire service.
● People were at risk of harm in the event of a fire emergency at night because not enough staff were on shift to implement the provider's current emergency plan or people's individual emergency evacuation plans.
● People's risk assessments were not always personalised and did not always provide staff with the information they required to keep people safe. For example, one person had a risk assessment which focused on their behavioural support needs. However, the risk assessment did not specify what the behaviours were or how staff should respond to support them. This meant staff did not have guidance to keep people safe.
● On the inspection we found the environment of the care home was not always safe. For example, we found an unattended ladder leading up through an open loft hatch. This meant people, some of whom were living with dementia, were at risk of injury if they attempted to use or move the ladder.
● Similarly, we found an unattended, unlocked cupboard on a corridor. The cupboard contained piping and no flooring. There was a risk of harm to any person who entered this area.
● At the entrance to a communal bathroom we observed a height differential between the flooring of the corridor and the bathroom floor. The provider had not placed a transition strip over the lip to make it safe. This meant people were at risk of harm from tripping.

The provider had not protected people from the risk of an unsafe environment and the risk of harm if a fire occurred. The provider remained in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

●Following our inspection, the provider informed us that they had increased the number of staff working at night from 3 to 4. Additionally, they secured the ladder and unlocked cupboard and addressed the trip hazard.
● People's skin integrity was protected. Where people presented with a risk of pressure sores, referrals were

made to healthcare professionals and staff followed their guidance. This included supporting people to reposition regularly.
● Where people were at risk of weight loss this was assessed and managed. Staff monitored their weight and fortified their meals to ensure people consumed sufficient calories. This meant people were protected against malnutrition.
● Risk assessments were undertaken for specific activities for example BBQs, garden activities and going into the community. The new manager was in the process of personalising people's risk assessments.

Using medicines safely
● People's medicines were not always stored safely. Published guidance states that medicines should be stored at a temperature below 25 degrees Celsius. This is because at higher temperatures some medicines, such as those in gel capsules, can be damaged and become ineffective for the purpose for which they were prescribed. Thermometers on both of the provider's medicines trollies showed temperatures above guidance.
●The service did not maintain a record of medicines storage temperatures and there were no contingencies in place for the actions to be taken should areas where medicines were stored became too warm. This meant people were at risk of receiving medicines with reduced effectiveness due to heat damage.

The failure to operate the proper and safe management of medicines is a further breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

● We checked people's medicines administration records (MAR) charts and found they were signed appropriately. This meant people received their medicines as planned.
● There were photographs of people within their MAR charts. This helped to ensure that staff administered medicines to the right person.

Systems and processes to safeguard people from the risk of abuse
● People felt safe and did not share with us any concerns they had about their care and support. One person told us, "I feel quite safe."
● Staff were trained to protect people from abuse. Staff we spoke with understood the actions they should take to safeguard people at risk of unsafe treatment.
● Where concerns had been raised the provider took appropriate action by reporting them to the local authority.

Staffing and recruitment
● The provider followed safe recruitment processes to ensure staff were suitable to provide care and support. The provider interviewed applicants, reviewed employment references, and confirmed the identities of prospective staff. They also carried out Disclosure and Barring Service (DBS) checks. These checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● The provider ensured there were enough staff available during the daytime to meet people's needs safely.

Preventing and controlling infection
● People were protected against the risk and spread of infection. Staff followed published guidance when wearing personal protective equipment (PPE). This included masks and gloves when providing personal care, and aprons and hair covering when preparing food.
● Staff received training in infection prevention and control, as well as food hygiene to keep people safe.
● Foods were stored safely in the fridge. Open foods were kept in sealed containers which were labelled and

dated. This prevented the use of out-of-date food.

Learning lessons when things go wrong

● The provider was inconsistent in learning lessons when things went wrong. Improvements were not always made where shortfalls were found. This has resulted in the repeated breaching of regulations across 3 inspections. You can read more about the governance of the service in the well-led section of this report.

Requires Improvement

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 our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The provider's oversight and governance of the service had not been effective. The service has been rated requires improvement at 3 consecutive inspections as was found to be in regulatory breach at each one. This meant there was a failure to consistently drive improvements at the service over time.
- The provider did not always assess and improve people's safety. The provider failed to update the service's fire risk assessment as directed by the London Fire Brigade or to ensure there were enough staff available over night to keep people safe in a fire emergency.
- People were not consistently protected by the provider's health and safety checks. Checks of the environment failed to identify the hazards we found to people of falling from height, tripping and access to an unsafe area.
- The provider's quality assurance checks did not always detect and address shortfalls. For example, we found medicines stored at temperatures above the permitted safe limit. The provider had not recorded the temperatures at which medicines were stored and had not taken action when temperatures were exceeded. This meant the provider's audits failed to ensure the proper and safe management of medicines.
- The provider's audits also failed to lead to improvements in the quality of the environment. The quality of maintenance at the service was poor. We identified several areas of the home where there was evidence of water damage. The resulting heavy brown staining and blistering paintwork had not been made good. Additionally, many doors were chipped. At the time of our inspection two communal bathrooms were out of service and awaiting improvements.
- Governance of the service did not always result in positive outcomes for people. Quality audits failed to recognise and rectify the lack of personalisation in people's bedrooms or make the home dementia friendly. The magnolia and white colour scheme did not support people's orientation or deteriorating vision in line with best practice.

The provider's failure to assess, monitor and improve the quality and safety of the services provided, and to mitigate the risks relating to health, safety and welfare of people is a breach of regulation 17 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

- At the time of our inspection the service's new manager had been in post for 2 weeks. People and staff

were positive about the new manager and the impact they made had since joining. One person told us, "There's a new manager and I've met them and my first impressions are favourable." Adding, "The new manager is getting things done. I've seen them talking to residents."

● A member of staff told us, "[The new manager] has changed so much here. When they came here they made changes everywhere. The manager had a meeting with us the first week and spoke about the issues and what we needed to do."

● Staff were also positive about the directors recently increasing their visibility at the service.

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

● The provider understood their responsibility to keep people, relatives, the local authority and CQC informed about important events at the service.

● When the service experienced a data breach and a loss of material it took action to prevent repetition and notified authorities including the police, fraud office, information commissioner's office, the local authority and CQC. The provider was open about the event with people, relatives and health and social care professionals.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Staff met regularly in team meetings. These were used to discuss people's changing needs and developments at the service. One member of staff said, "I am happy here. I would recommend this as a place to work to other people."

● The new manager planned to reinstitute regular meetings for people and their relatives and to conduct surveys of their views regarding people's care and support. They were developing an action plan to address issues fed back to them by people and relatives since joining the service. These issues included supporting people to personalise their bedrooms. We will be checking to confirm that actions agreed at residents' meetings on improvements to the service have been carried out.

● People and staff came from diverse backgrounds. People's cultural and spiritual needs were assessed and supported, and people's preferences were recorded.

Continuous learning and improving care; working in partnership with others

● The service had been placed into the local authority's 'provider concerns' framework. This process involved close monitoring of the service by the local authority and an increase in support to the service from health and social care professionals. This included regular meetings, quality assurance checks and training. This meant the service had access to support and guidance on improving care and support to people.

● At the inspection we recommended to the manager that they attend the local authority's provider's forum and registered manager network. These offered the new manager and the service the opportunity to continuously learn and receive up to date information about best practice.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess the risks to the health and safety of people of receiving care and treatment; to do all that was reasonably practicable to mitigate risk; to ensure that the premises used were safe for their intended purpose and to operate the proper and safe management of medicines. Regulation 12(1)(2)(a)(b)(d)(g)

The enforcement action we took:

We served a Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to assess, monitor and improve the quality and safety of the services provided and to mitigate the risks relating to health, safety and welfare of people. Regulation 17(1)(2)(a)(b)

The enforcement action we took:

We served a Warning Notice.