Barchester Healthcare Homes Limited

# Marple Dale Hall - The New Windsor

## 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 well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

About the service
Marple Dale Hall – The New Windsor is a care home providing personal and nursing care for 51 people at the time of the inspection. The service can support up to 63 people. The service provides care to people living with dementia, physical disabilities and/or an acquired brain injury.

People's experience of using this service and what we found
We identified concerns about medicines, person-centred care and governance. These amounted to breaches of legislation. The provider and registered manager commenced immediate action to resolve the issues identified.

Staff did not always record the administration of medicines clearly and some medicines were out of date. The service followed safe recruitment practices and records contained the required documentation. There were arrangements for safeguarding people. Care workers had been provided with training on safeguarding people and knew what action to take if they were aware that people were being abused.

People did not always receive person-centred care. People told us they often had to wait for care. Care plans had been reviewed but contained conflicting information. Activities were taking place in parts of the building, but people cared for in bed were at risk of social isolation.

People were not supported to have maximum choice and control of their lives on the occasions they had to wait for care. However, staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Quality assurance systems were in place to assess, monitor and improve the quality and safety of the services provided. However, audits had not identified the issues we found during the inspection. The management team were receptive to our feedback and started to make the required improvements immediately. They were committed to making improvements and ensuring effective systems were in place.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 19 November 2019) and there were two breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection improvement had been made in relation to general monitoring of care and oral healthcare. However, the provider was still in breach of regulations in relation to governance and medicines management.

Why we inspected
The inspection was prompted in part due to concerns received about the management of people's care

needs, staffing and medicines management. A decision was made for us to inspect and examine those risks.

As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

We have found evidence that the provider still needs to make improvements. Please see the safe, effective and well-led sections of this full report.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained the same. This is based on the findings at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Marple Dale Hall – The New Windsor on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified continued breaches in relation to medicines management, person-centred care, and governance at this inspection.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

**Is the service effective?**

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

**Is the service well-led?**

Requires Improvement

The service was not always well-led

Details are in our well-Led findings below.

# Marple Dale Hall - The New Windsor

**Detailed findings**

## Background to this inspection

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

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 an inspector and a medicines inspector.

Service and service type
Marple Dale Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager who was in the process of registering with the Care Quality Commission. This means that when registered, they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We asked the local authority and Healthwatch for information about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with ten people who used the service and we spoke with five relatives. We spoke with 14 staff members including the general manager, the deputy manager, a quality and compliance manager, nurses, care staff, a housekeeper and a member of the catering team. We also spoke with two health and social care professionals for their view of the service.

We reviewed a range of records including care records for eight people. We looked at medicines and records about medicines for ten people. We spoke with the two nurses who had responsibility for administering medicines on the days of the inspection. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including health and safety records were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. The general manager provided us with information about compliments, complaints and safeguarding investigations. We also spoke with two professionals who regularly visit the service.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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.

Using medicines safely

At the last inspection the provider had failed to ensure medicines were safely managed. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

● Records about medicines did not always show that they were managed safely. Staff did not always complete records of administration accurately and the quantity of medicines in stock was not always recorded. Therefore, it was not always possible to account for all the medicines. The records about creams did not always show that they were managed safely.
● People were at risk of being given doses of some of their medicines too close together or at the wrong times because the provider's systems did not include checks to make sure this did not happen.
● Written guidance was in place when people were prescribed medicines to be given 'when required' but the guidance was not accurately personalised, and staff did not have the information to tell them when someone may need the medicine. When medicines were prescribed with a choice of dose there was no information about which dose to choose.
● A system was in place to make sure that medicines administered in a patch formulation were rotated safely but staff failed to rotate them in line with the manufacturers' directions.
● Waste and unwanted medicines were not stored safely in line with current guidance.

The provider had again failed to ensure that medicines were safely managed. This was a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff told us that they felt that staffing levels were inconsistent, and people sometimes had to wait for care longer than they expected.
● The general manager did not agree that the home was short of staff. They said. "We use a deployment tool to work out how many staff we need to work on each shift. The home is not usually short staffed."
● People told us they often had to wait for care. One person said they had waited a significant amount of time the night before the inspection for a staff member to assist them. The management team told us that they had been short staffed by one member of staff the night before the inspection. We have addressed this

in the effective section of this report.
● Recruitment procedures were safely in place.

Systems and processes to safeguard people from the risk of abuse
● Most people told us they felt safe at Marple Dale Hall. Two people said they did not feel safe at night because staffing levels could sometimes be low.
● The provider ensured that systems and processes to protect people from the risk of abuse were in place and lessons were learnt when things went wrong.
● The provider ensured that accident and incident reporting procedures were in place; monthly reviews and trend analysis were conducted to identify areas of risk.
● Staff were familiar with safeguarding and whistleblowing procedures.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● The provider ensured there were systems in place to keep people safe from harm. Risks to people's safety were assessed and recorded. Risk assessments contained guidance for minimising risks to people. Staff we spoke with were aware of how to keep people safe from these risks.
● The management team had taken action to learn from a recent accident following a recommendation from the local authority safeguarding team. One person had recently been provided with a safety device in response to an injury they had sustained.
● There were procedures in place for dealing with emergencies. Personal emergency evacuation plans (PEEPs) were in place for people. These contained information for supporting people in the event of a fire or other emergencies.
● Records showed that a range of maintenance and safety inspections had been carried out by specialist contractors to ensure people lived in a safe environment. These included inspections of the portable electrical appliances, hoists, fire alarm, emergency lighting and electrical installations.

Preventing and controlling infection
● We were assured that the provider was promoting safety through hygiene practices of the premises; signposting was provided in relation to 'touch-point' cleaning schedules and communal bathroom cleaning tasks.
● Personal spaces were clean, hygienic and well maintained.
● We were assured that staff were provided with the appropriate PPE, COVID-19 training and essential COVID-19 guidance and information was being circulated and complied with.
● Safe visiting arrangements were in place; negative tests needed to be provided, PPE needed to be worn and temperature checks needed to be taken before visits took place.

Requires Improvement

# Is the service effective?

## Our findings

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

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

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

- People sometimes had to wait a significant length of time for staff to answer their call bells.
- People told us that care was overwhelmingly task based which they felt impacted on the quality of their care. A relative told us, "It used to be that staff had time to spend on the extra little things, like helping [Name] to write a letter, or to tune their television in. Now it seems [Name] just gets the bare minimum." One person said, "I would like more than my allocated two showers a week but if I ask the staff they say there are not enough of them to support me with this."
- Two people said that they could routinely hear call bells sounding during the night which disturbed their sleep.
- Staff demonstrated that they knew people's needs well. However, care plans were lengthy and did not consistently and clearly reflect people's current care needs. For example, one person's plan contained conflicting information about their care needs in relation to eating.
- People told us they felt socially isolated. There was limited assurance that people who were able to spend time out of their bed were actively encouraged to do so. Activities and social simulation for people cared for in bed were minimal.

The provider had failed to ensure staff provided people with individualised care which met their needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People's needs were assessed before they began to use the service. Assessments involved professionals, people and their families.

Staff support: induction, training, skills and experience

- Staff had received support and the required training to enable them to carry out their duties. Training provided included safeguarding, health and safety, moving and handling, infection control, dignity and respect and equality and diversity. Documented evidence was provided.
- The management team kept a training record to make sure staff kept up to date with their training. Staff had been nominated for training that was overdue. Staff told us they had regular supervision sessions to discuss any concerns and identify further training and development needs.

Supporting people to live healthier lives, access healthcare services and support; Supporting people to eat and drink enough to maintain a balanced diet

● Staff completed charts that captured people's food and fluid intake. The overall quality of record keeping had improved since the last inspection. However, further improvement was required relating to the accurate recording of medicines and continence care.
● People told us they regularly had to use their call bell to request a drink as staff were often too busy to bring them one.
● People told us they were happy with their food options. However, one person told us the food was not always hot enough to enjoy and staff were not allowed to re-heat their food for safety reasons. Another person said that the quality of the food that was offered in alternative textures could be inconsistent.

Staff working with other agencies to provide consistent, effective, timely care; Adapting service, design, decoration to meet people's needs
● Professionals said staff knew people's health needs, made referrals to health professionals appropriately and followed their advice. One professional said, "I have found staff helpful and responsive."
● People's rooms were personalised with their own furniture which made them familiar and homely.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

● People's consent was sought before staff supported them. For example, about personal care and how they wished to spend their day. Where people were able to make decisions for themselves, staff respected their decisions. One person said, "The staff are brilliant. They are caring and really consider my needs."
● People's legal representatives, relatives and professionals were consulted and involved in best interest decisions. For example, about the use of bedrails, medication and personal care.
● People told us their choices were sometimes restricted because they had to wait for care. For example, one person told us they often could not go to bed at the time they chose to because they regularly had to wait for over an hour for staff to be available to support them.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service's new management structure and leadership was stabilising. 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

At the last inspection the provider had failed to ensure governance systems protected people from the risk of harm. This was a breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

● Oversight and governance by the provider had not always been effective and did not drive improvement. Audits had been regularly completed but they had failed to identify areas of concern found during this inspection.

The provider had again failed to do all that was reasonably practicable to mitigate the risks to the health and safety of service users receiving care or treatment. This was a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had a new general manager who had been in post three months at the time of the inspection. They were in the process of registering with the CQC.
● The general manager had ensured they understood their other responsibilities fully. This included ensuring CQC was notified of events and incidents in the service as required.

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; Continuous learning and improving care
● The management team were responsive and open to all feedback on the day of inspection.
● External professionals told us they had found the staff and management at the home helpful in terms of providing information when requested.
● The management team reviewed incidents, complaints and events as part of the provider's continuous monitoring process.
● The general manager understood their responsibilities to adhere to the duty of candour and be open and transparent in the event of something going wrong.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

● Staff were observed to be respectful and supported individuals with compassion on the day of the inspection.

● Care staff had consulted with people and their representatives regarding how they could meet the needs of people. The was a monthly 'resident of the day' review and a keyworker system.

● External feedback was sought from the local authority commissioning team and the Clinical Commissioning Group. Both parties provided positive feedback about the care at Marple Dale Hall.

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

● People told us that they hoped the new management team would be receptive to their feedback. The general manager told us "We are working hard to improve all elements of care at Marple Dale Hall. Specifically, we plan to improve how we engage with our residents and staff to ensure we gather their feedback and improve their experience."

● People and their relatives described the communication with the service and general manager in good terms. A relative said, "The general communication has been good, but I would appreciate if the service would take the initiative to provide some personalised feedback about my loved one whilst I am unable to visit."

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<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The provider had failed to ensure staff provided people with individualised care which met their needs. Regulation 9 (1) (b) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider did not ensure that medicines were managed safely.<br>Regulation 12 (2) (a) (b) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider did not have effective systems in place to ensure the quality and safety of the service.<br>Regulation 17 (2) (a) |