Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru
Care and Social Services Inspectorate Wales

Inspection Report on

Morris House Nursing Home

54-56 Eaton Crescent

Uplands

SA1 4QN

Date of Publication

Monday, 16 April 2018

Description of the service

Morris House is a care home with nursing and is situated in the Uplands area of the City and County of Swansea. The home is registered to provide accommodation and nursing and/or personal care for up to twenty-five older people requiring nursing or personal care. The provider of the service is Morris House Ltd and there is a manager in place who has day-to-day management responsibility.

Summary of our findings

1. Overall assessment

People live in an environment that places them at risk of harm and impacts on their well-being. The provider's quality assurance processes failed to identify that people do not live in a safe environment. Care workers have not always been adequately trained or supervised.

2. Improvements

At the last inspection, the registered persons were advised that improvements were needed in relation to the following two (2) Regulations;

- Regulation 17(1) (a) because individual Deprivation of Liberty (DoLS) applications and documentation were not being retained in people's own care records. This has been met.
- Regulation 27 (4) because the responsible individual (RI) had not made a record of their visits to the home to assess and record the quality of care being provided.

We also recommended that the new person centred care plans that were being researched were implemented. This has not been met.

3. Requirements and recommendations

Section five of this report sets out our recommendations to improve the service and the areas where the care home is not meeting legal requirements. These include the following:

- Conduct of Care Home: The registered person has not made proper provision to ensure that the health and welfare needs of people accommodated at the home are adequately met.
- Management: Although it is acknowledged that the registered provider has regularly visited the home to ensure the service provision is quality assured, they have not recorded the visits as required.

Details of the actions required are set out in the non-compliance report attached.

1. Well-being

Summary

People could not be assured that they live in a home with proper provision for their health and welfare. People do not benefit from a healthy diet or attention to nutrition and have a limited choice of meals. We informed the responsible individual that the service was not meeting legal requirements which is a serious matter and a non compliance notice has been issued

Our findings

People living in Morris House cannot be confident that they will feel safe. We found unacceptable and unnecessary risks to the safety and well-being of people living in the home. This is evidenced further in the environment section of this report.

People do not benefit from attention to nutrition and have a limited choice of meals. Care records contained nutritional assessments and care plans. However, we saw no evidence that these guidelines were being followed by care workers. For example, nurse assessors had recently commented on two occasions where people were not being offered their breakfast or a drink before 10am; as we saw no evidence that this had been addressed, we reiterated this issue to the manager, who told us they would rectify the issue immediately. People who had difficulty eating independently were not offered encouragement and support at mealtimes. For example, one person whose care records stated that they were losing weight had a meal but was not eating it. No assistance was offered and after they had fallen asleep, a care worker took the meal away, untouched. When we examined this person's nutritional records, we found that it had not been completed, so we requested that staff completed this immediately. We then noted that the care worker documented the meal as having been 'refused', which was not correct. Throughout three mealtime observations, we did not see anyone offered meal choices. We also noted that there were no methods of helping people who were confused or disorientated to make informed decisions about what they wanted to eat. The chef showed us how they worked to a rolling rota of meals but the options were not made available to people in the home. Menus should have been displayed

on a whiteboard on the dining room wall but we found that the information was not updated daily; For example, Friday's lunch was still being displayed on the following Monday. We looked at food stocks and found that a good stock of food was kept in stock. However, dry foods were stored in three places, one of which was located in a position that necessitated the staff member walking through a dirty laundry area and a very warm smoking room to get items and then return the same way. Next to the kitchen, there was a table with dozens of food supplements stored on it. One care worker told us that this was where they were always stored. There was a noisy environment during each meal time we observed; on one occasion, there were two televisions on with high volumes, each with different programmes and no one watching. Care workers did not always treat people with respect. For example, we overheard one care worker who referred to people as the, 'normals,' the 'softs' and 'the diabetics' at one mealtime we observed. This shows that not only are people treated with disrespect, but are also at risk of malnutrition because they do not receive the identified support to maintain a healthy diet of their choice.

2. Care and Support

Summary

People's individual support needs are not clearly described and understood. We informed the responsible individual that the service was not meeting legal requirements which is a serious matter and a non compliance notice has been issued

Our findings

People's individual support needs are not clearly described and understood. This was because care plans were generic and utilised a template that was not personalised according to individual need. Statements such as, 'unable to use call system' or 'known history of dementia/confusion' remained on each person's care plan, regardless of whether they were relevant or not. In addition, information was lacking in care plans.
We found a variety of healthcare assessments that gauged people's mobility, daily living skills, communication, pressure area care and skin integrity, but the information they contained was not clearly transferred to care plans for care workers to follow.
We found that some people had a history of poor oral hygiene, but their care plans did not inform care workers about how this was to be addressed.
One person told us she was not able to press her call bell due to rigidity in her hands but her care plan recorded that she could use it.
One person had a list of behavioural issues documented by a social worker that would necessitate them having an appropriate care plan in place in order to be supported appropriately. However, there was no relevant care plan or risk assessment in the person's care records.
At the last inspection, we notified the provider that Deprivation of Liberty Safeguards authorisations needed to be in place for care workers to refer to in people's individual care records, We found that the issue had been resolved.
We had also recommended that person centred care plans were implemented to enable people to be involved in their care and welfare.
There were 'This is Me' booklets that were designed to describe the person, their preferences and interests in some people's care records, but these were predominantly

blank. This recommendation had not been addressed. We conclude that people cannot expect to receive the right care and support at the right time in the way they want it.

Confidentiality is not maintained. This was because care records were kept insecurely in an unlocked nurses' office, which was situated close to the lounge and the front door. Throughout both inspection visits the nurses' office was unlocked. This meant that people's care records were potentially available for anyone to view who was entering or leaving the premises. To protect people's confidentiality, these records must only be available to care workers who were authorised to access them. We told the manager that this must be rectified immediately and we saw that the door was locked when we left. Employee personnel records were securely stored in another office. People were safe from unauthorised visitors entering the building, as all visitors had to ring the front door bell prior to gaining entry and were requested to complete the visitor's book when entering and leaving the home. This demonstrates that people's confidentiality is only partially maintained.

3. Environment

Summary

People living in Morris House are at risk of harm because the premises are not safe. Action is needed to ensure that people are safe, feel comfortable and feel valued. We informed the responsible individual that the service was not meeting legal requirements which is a serious matter and a non compliance notice has been issued

Our findings

Due to the environment found on inspection people cannot be assured that they are valued. People did not have access to hot water, either in their rooms or the bathrooms; this meant that care workers had to collect hot water from elsewhere in the home in order for people to have a wash every day. The temperature of the water in the single bedroom that did have hot water was very high and was therefore a hazard for the occupant of that room who was at risk of scalding themselves. We also noted that although the water in both bathrooms was cold, there were no blinds or curtains in either bathroom to provide privacy for anyone who did use them.

One person's bedroom had wiring exposed from the electrical socket which meant that they, together with any care worker or visitor in the room, were at risk of electrocuting themselves.

We saw wall lights that were out of people's reach whilst they were in bed and other wall lights that were either broken or had no bulbs in them; this meant that some people did not have access to any lighting at night.

There was a screw sticking out of a broken wardrobe handle which anyone could cut themselves on.

Other bedrooms had exposed hot pipes along the walls and in the en-suites, which meant that people, care workers or visitors in the room, were at risk of burning themselves if they touched them.

Hallways and landings contained large piles of boxes, old furniture, manual handling equipment and a bed frame. These items presented serious hazards for people with poor mobility or sight.

We found bedrooms with broken window blinds; this meant that there was no privacy for the occupant of these rooms. Bedroom windows on one side of the property were directly opposite the neighbouring property's windows; one such bedroom did not have a curtain or window blind to provide any privacy for the occupant.
We saw an en-suite toilet that was too narrow and therefore not accessible for anyone who used a walking frame or needed assistance to access it. Several en-suite toilets were on raised platforms to accommodate the plumbing, which meant people with mobility issues or poor eyesight would find them difficult to access. We found one bedroom with a missing door to the en-suite toilet and two other rooms had en-suite doors missing that had been replaced with curtains. This illustrates that people's well-being is compromised because the environment they live in is unsafe and does not make them feel valued.

People living in Morris House are at risk of harm because the premises are not safe. We found one bedroom that had a broken electrical socket with exposed wiring, several bedrooms with hot and exposed heating pipes near beds, bedroom wall lights with bulbs missing and a screw sticking out of a broken wardrobe handle. There were numerous trip hazards, such as frayed carpets, throughout the premises.
We examined certificates that evidenced the boiler, hoists, the lift, gas and the stair-lift had all been serviced when due.
The medication trolley was not secured to the wall; the manager explained that the location of the nurses' office had recently been moved and that as a result, the trolley was not yet secured. We asked the manager to rectify this immediately and we have since been given reassurances that this has now been addressed.
We found a narrow stairway that led up to a loft which was full of old furniture, electrical equipment and other combustible items. This led to the boiler room where we found the door unlocked and had a window with a three-storey drop and no window restrictor in place. There were boxes of chemicals in the downstairs hallway and a store cupboard by the downstairs toilet that contained bottles of hand wash, alcohol gel and carpet shampoo. This room had a sign to keep locked but was unlocked throughout the inspection. We also found chemicals stored in a sluice room; this room had very hot water and was unlocked. This meant that vulnerable and possibly confused people could access these items without anyone's knowledge. We told the manager that these issues must be rectified immediately. We saw that these were addressed before we left. This evidences that people at Morris House are not supported in a safe environment.

4. Leadership and Management

Summary

People live in a care home that is not physically safe. There are no quality assurance processes in place that would identify that people did not live in a safe, homely and comfortable environment. Although it is acknowledged that the registered provider has regularly visited the home to ensure the service provision is quality assured, they have not recorded the visits as required. We informed the responsible individual that the service was not meeting legal requirements which is a serious matter and a non compliance notice has been issued.

Our findings

We saw no evidence of a quality assurance process that involved consultation with people that used the service, their families or representatives. At the last inspection, we notified the responsible individual that under regulation 27 (1) of The Care Homes (Wales) Regulations 2002 because it is expected that they regularly visit the home in order to assess and record the quality of care provided. We therefore checked on this inspection and found that the issue had not been resolved - although it is acknowledged that the registered provider has regularly visited the home since the last inspection in February 2017, they have not recorded the visits as required. We therefore informed the responsible individual that the service was not meeting legal requirements which is a serious matter and a non compliance notice has been issued. We also saw that there had been no meetings arranged for people and their relatives to voice any concerns. This meant that people did not have the facility to meet with the management of the home to have their concerns recorded and addressed. We found that the provider had not issued any surveys to people in the service or their relatives.

A complaints policy and procedure was available in the office for anyone who needed it - relatives and people who were able to told us they knew how to make a complaint. We noted that there had been two formal complaints logged since the last inspection and the home had resolved each issue to the complainant’s satisfaction. Therefore, people cannot

be reassured that the home consults with them regarding the quality of care provided to them, or has an overall commitment to continuous improvement.

There are no clear systems that monitor the quality of support provided to people. For example, there were no regular audits. This meant that the home did not monitor the systems they had in place and meant that the manager was unaware of any issues in order to reduce the likelihood of them being repeated. The home had not arranged staff meetings for care workers to discuss their roles and any concerns they had. We conclude that people's care and support needs are not subject to ongoing review and consideration, nor are they consulted or have their views sought through an effective quality assurance process.

There are suitable procedures in place to monitor care workers' recruitment and inductions. We looked at four employees' personnel records; each file demonstrated that all the required employment checks were in place before new employees started to support people. This included references, explanations to any gaps in employment**,** photo identification and Disclosure and Barring Service checks. One care worker we spoke with told us that their induction was, *"OK"* whilst another care worker said, *"It was enough to know what to do when I started."* This illustrates that people can be reassured that the provider has developed satisfactory processes to monitor employee recruitment**.**

There is no clear and robust system in place to monitor care workers' training. It was difficult to evidence that all employees were up-to-date with their essential training, as training records we examined contained a limited amount of information. Care workers have not been given clear support and direction throughout the past year. This is because since the last inspection, care workers had not been given regular one-to-one supervision. Formal supervision is important as it provides an opportunity for confidential discussion regarding support and professional guidance, training and development needs in a formal setting and have the conversations recorded. However, we noted that all care workers had received supervision in the last two months. This shows that people receive care and support from a service which requires further commitment to employee training and support**.**

5. Improvements required and recommended following this inspection

5.1 Areas of non compliance from previous inspections

At the previous inspection, the registered persons were advised that improvements were needed in relation to the following two regulations;

- Regulation 17: because individual Deprivation of Liberty (DoLS) applications and documentation were not being retained in people's own care records. This has been met.
- Regulation 27: because the responsible individual (RI) had not made a record of their visits to the home to assess and record the quality of care being provided.

We also recommended that the new person centred care plans that were being researched were implemented. This has not been met.

5.2 Recommendations for improvement

During this inspection, we identified areas where the registered person is not meeting the legal requirements and this is resulting in risk and poor outcomes for people using the service. Therefore we have issued a non compliance notice in relation to the following*:*

- Conduct of Care Home: The registered person has not made proper provision to ensure that the health and welfare needs of people accommodated at the home are adequately met.
- Management: The registered provider has not recorded their visits to the care home to ensure the service provision and the environment is quality assured.

Details of the actions required are set out in the non-compliance report attached.

The following is a recommended area of improvement to promote positive outcomes for people:

- The home should maintain people's confidentiality regarding the storage of care records, so that they are only available to care workers who are authorised to access them.

6. How we undertook this inspection

This was a full inspection that was undertaken as part of our inspection programme, following concerns raised about the care and well-being of people who live in the home. During the visits we considered the well-being of people, care and support, leadership and management and the environment of the service. We made two unannounced visits to the home on:

- 9 March 2018 between 9.30am and 16.00pm
- 12 March 2018 between 11.00am and 15.30pm

Both visits were undertaken by two inspectors.

The following methods were used:

- We walked around the premises on each of our visits
- We met and spoke with seven people living in the home and three relatives.
- We spoke with three care workers, one nurse and the manager.
- We examined five people's care records.
- We examined four employee personnel, training and supervision records.
- We used the Short Observational Framework for Inspection (SOFI). The SOFI tool enables inspectors to observe and record care to help us understand the experience of people who cannot communicate with us.
- We looked at a range of records including the home's statement of purpose, service user guide and staffing rotas.

Further information about what we do can be found on our website www.cssiw.org.uk

About the service

Type of care provided	**Adult Care Home - Older**

Registered Person	**Morris House Nursing Home Limited**
Registered Manager	
Registered maximum number of places	**25**
Date of previous CSSIW inspection	**15/2/2017**
Dates of this Inspection visits	**09/03/2018 and 12/03/2018**
Operating Language of the service	**English**
Does this service provide the Welsh Language active offer?	**No**
Additional Information:	

Care Inspectorate Wales

Care Standards Act 2000

Non Compliance Notice

Adult Care Home - Older

This notice sets out where your service is not compliant with the regulations. You, as the registered person, are required to take action to ensure compliance is achieved in the timescales specified.

The issuing of this notice is a serious matter. Failure to achieve compliance will result in Care Inspectorate Wales taking action in line with its enforcement policy.

Further advice and information is available on CSSIW's website
www.careinspectorate.wales

Morris House Nursing Home

54-56 Eaton Crescent
Uplands
SA1 4QN

Date of publication: Monday, 16 April 2018

Well-being	Our Ref: NONCO-00005686-LDPR
Non-compliance identified at this inspection	
Timescale for completion	**31/05/18**
Description of non-compliance/Action to be taken	**Regulation number**
The registered person has not ensured that the care home is conducted so as to promote and make proper provision for the health and welfare of service users.	12 (1) (a)

Evidence

The registered person is not compliant with regulation 12 (1) (a) of The Care Homes (Wales) Regulations 2002.
This is because during an inspection undertaken on 9 March 2018 and 12 March 2018, we found that the registered person had not ensured that the care home was conducted so as to promote and make proper provision for the health and welfare of service users.
The evidence was as follows:

People's well-being was compromised because of the environment ;

- People did not have access to hot water, either in their rooms or the bathrooms; this meant that care workers had to collect hot water from elsewhere in the home in order for people to have a wash every day (Regulation 13 (4) (c).
- The temperature of the water in the single bedroom that did have hot water was very high and was therefore a hazard for the occupant of the room, who was at risk of scalding themselves (Regulation 13 (4) (c).
- One person's bedroom had wiring exposed from the electrical socket which meant that they were at risk of electrocuting themselves (Regulation 13 (4) (a), (Regulation 13 (4) (c).
- We saw wall lights that were out of people's reach whilst they were in bed.
- We saw wall lights that were either broken or had no bulbs in them; this meant that some people did not have access to any lighting at night.
- There was a screw sticking out of a broken wardrobe handle which anyone could cut themselves on (Regulation 13 (4) (a), (Regulation 13 (4) (c).
- Other bedrooms had exposed hot pipes along the walls and in the en-suites which meant that people were at risk of burning themselves if they touched them (Regulation 13 (4) (a)).
- Hallways and landings contained large piles of boxes, old furniture, manual handling equipment and a bed frame. These items caused clear hazards for people with poor mobility (Regulation 13 (4) (a), (Regulation 13 (4) (c).
- We found bedrooms with broken window blinds; this meant that there was no privacy for the occupant of these rooms.
- Bedroom windows on one side of the property were directly opposite the neighbouring property's windows; one such bedroom did not have a curtain or window blind to provide any privacy for the occupant.
- Water in both bathrooms was cold (Regulation 13 (4) (a), (Regulation 13 (4) (c).
- There were no blinds or curtains in either bathroom to provide privacy for anyone who

used them.

- One en-suite toilet was too narrow and therefore not accessible for anyone who used a walking frame or needed assistance to access it (Regulation 13 (4) (c).
- Several en-suite toilets were on raised platforms which meant people with mobility issues would find them difficult to access (Regulation 13 (4) (c).
- One bedroom had a missing door to the en-suite toilet.
- Two other rooms had en-suite doors missing that had been replaced with curtains.
- One bedroom had a missing door to the en-suite toilet.
- Two other rooms had en-suite doors missing that had been replaced with curtains.
- There were no blinds or curtains in either bathroom to provide privacy for anyone who used them.
- Hallways and landings contained large piles of boxes, old furniture, manual handling equipment and a bed frame. These items caused clear hazards for people with poor mobility Regulation 13 (4) (a), Regulation 13 (4) (c).

Care workers are not adequately trained to ensure peoples' care needs are most effectively and safely met, this is because:

- There is no clear system in place to monitor care workers' training.
- Care workers have not been given clear support and direction throughout the past year.
- Care workers had not been given regular one-to-one supervision over the past year.

People's individual support needs were not clearly described and understood because care plans were generic and not personalised according to individual need.

- There were care and support needs on people's care plans that were not relevant to the person they described. For example, one person told us she was not able to press her call bell but her care plan recorded that she could.
- Care plans contained assessments, but the information they contained was not always transferred to care plans. For example, one person was assessed as having poor oral hygiene but there was no record of this in their care plan.
- One person had a list of behavioural issues documented, but there was no care plan or risk assessment in place to manage these behaviours.

People are at risk of malnutrition because they do not receive the identified support to maintain a healthy diet of their choice.

- People who had difficulty eating independently were not offered support at mealtimes.
- One person who was losing weight was not offered assistance to eat and a care worker took the meal away, untouched, and then documented the meal as having been refused.
- Care records contained nutritional assessments, but we saw no evidence that these guidelines were being followed by care workers. For example:
- Nurse assessors had commented on two occasions where people were not being offered their breakfast or a drink before 10am and we saw no evidence that this had been addressed.
- People were not offered meal choices. Meal options were not made available to people in the home. Menus displayed on a whiteboard in the dining room were not updated daily.
- There were no methods of helping people who were confused to make informed decisions about meal choices.
- There was a noisy environment during meal times; on one occasion, there were two televisions on and no one watching.
- Care workers treated people disrespectfully - one care worker referred to people as the, 'normals,' the 'softs' and 'the diabetics.'

The impact for people using the service is:
People's health and welfare is seriously compromised because;

- People cannot expect to receive the right care and support at the right time in the way they want it and as a result, are at risk of neglect.
- People's individual care needs which includes their personal hygiene needs and nutritional needs are not being adequately met which may seriously affect their health and well-being.
- The environment they live in does not make them feel valued.
- People may feel demotivated and undervalued living in an unhomely environment. This may adversely affect their mental health and well-being.
- People cannot be confident that they will feel safe because of the amount of hazards and environmental issues in their home and this may affect their health and well-being.
- People could suffer serious harm by having access to potentially harmful substances.

Leadership and Management	Our Ref: NONCO-00005688-VPYH
Non-compliance identified at this inspection	
Timescale for completion	**31/05/18**
Description of non-compliance/Action to be taken	**Regulation number**
The responsible individual has not regularly undertaken regulation 27 visits to the home.	27 (1)

Evidence

The registered person is not compliant with regulation 27 (1) of The Care Homes (Wales) Regulations 2002.
This is because during an inspection undertaken on 9 March 2018 and 12 March 2018, we found that the registered provider had not recorded his visits to the care home in accordance with this regulation. Visits shall take place at least once every three months and may be unannounced.
The evidence observed was as follows:

- There were no robust systems that monitored the quality of support provided to people. Regular audits had not been undertaken. This meant that the home did not monitor the systems they had in place and also meant that the manager was unaware of any issues in order to reduce the likelihood of them being repeated.
- There was no evidence of regulation 27 reports (Regulation 27 (5)).
- We saw no evidence of a quality assurance process that involved consultation with people who used the service, people's families or their representatives (Regulation 27 (4) (a), (Regulation 25 (1), (2) (a), (2) (b) (i, ii)).
- There have been no meetings arranged for people and their relatives to voice concerns. This meant that people did not have the facility to meet with the management of the home to have their concerns recorded and addressed (Regulation 25 (b) (i) (ii)).
- The provider had not issued surveys to people in the service, their relatives or representatives (Regulation 25 (b) (i) (ii)).
- There had been no staff meetings for care workers to discuss their roles and any concerns (Regulation 25 (b) (iv)).
- We saw no evidence of a quality assurance process that involved consultation with persons working at the care home (Regulation 27 (4) (a), Regulation 25 (b) (iv)).
- Care workers have not been given regular, formal, individual supervision (Regulation 25 (b) (iv)).

The impact for people using the service is:

- People cannot expect to receive the right care and support at the right time in the way they want it and as a result, are at risk of neglect.
- People are at significant risk of having care provided by care workers who are not adequately trained to ensure their care needs are most effectively and safely met.
- Care workers are at risk of injury from delivering care to people when they have not received the required training to carry out the tasks.