Runwood Homes Limited

Memory House

Inspection report

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24 October 2022

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Memory House is a residential care home providing accommodation and personal care to up to 39 people. The service provides support to people living with dementia. At the time of our inspection there were 34 people using the service. The care home accommodates people in one adapted building.

People's experience of using this service and what we found

Management did not have adequate oversight of the service and systems in place to monitor the quality and safety of the service were not operated effectively. There was a lack of recognition and understanding of risk with a lack of robust assessments and controls in place to protect people and keep them safe. The provider's systems did not identify where things were going wrong.

There were no clear management systems followed in practice, monitored and reviewed that enabled effective recruitment, maintenance and retention of staffing levels. Recruitment practices were not robust because checks were not always complete. Whilst the staff, at the time of our inspection, showed commitment and compassion towards people they were supporting, there were not enough of them to keep people safe and meet their needs effectively. There was a high incidence of unwitnessed falls and staff were not able to spend meaningful time with people.

New and inexperienced staff members were not sufficiently supported to deliver safe and appropriate care. Learning and development was not managed and planned in a way that ensured staff had the opportunity to build on their knowledge base and develop their skills to carry out their roles and meet people's specific needs.

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. People had choice and access to enough food and drink throughout the day and night.

People received their medicines in a safe and supportive way and were supported to access healthcare services and support as and when they needed.

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 good (Published 7 January 2022)

Why we inspected
This inspection was prompted by concerns received about falls, safeguarding incidents and staffing levels. A decision was made for us to inspect and examine those risks.

We undertook a focused inspection to review the key questions of Safe, Effective and Well-Led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.
The overall rating for the service has changed from good to inadequate based on the findings of this inspection.
We have found evidence that the provider needs to make improvements. Please see the Safe, Effective and Well-led sections of this full report.
Senior management acknowledged our findings and started to take action to mitigate risk and address our concerns during the 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 COVID-19 and other infection outbreaks effectively.

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 Memory House on our website at www.cqc.org.uk.

Follow up
We will request an action plan 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.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Memory 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
The inspection team consisted of two inspectors.

Service and service type
Memory 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. Memory 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.
Inspection activity started on 18 October 2022 and ended on 31 October 2022. We visited the home on 18, 20

and 24 October 2022.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all this information to plan our 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 six people who used the service and two relatives. We observed how staff supported people in their day to day lives at Memory House throughout the three days on site.

We spoke with the registered manager, two regional operational managers, the deputy manager, the estates manager, eight care staff, the housekeeper, the maintenance person and the cook.
We reviewed a range of documents and records. These included people's care, support and medicine records, policies and procedures, staff personnel records relating to recruitment, training, development and supervision, and records relating to the running of the service.

Inadequate

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 good. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- Staff recruitment checks were not always complete.
- References were not always sought or checked, exploration and validation of gaps in employment were not recorded, two recruitment files did not evidence a Disclosure and Barring (DBS) check had been carried out. DBS checks provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.
- The 'rights to work' status of staff from overseas was unclear; their files included student and skilled worker status, there were no clear details of current address.

This is a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There were not enough staff to provide safe, quality, person-centred care to people.
- Risks around social isolation had not been considered for those who preferred to not participate in group activities or were cared for in their bedrooms. For those people staff interaction was limited, and task focused. One person was very tearful. They were immobile and remained in their room. They were lonely and depressed; they said, "Staff are so busy they do not have time for a conversation". After spending time and talking with this person their mood lifted and they were smiling.
- Another person cared for in their bedroom said, "Staff are lovely, they work very hard and will do anything I ask, however, they are too busy to come and talk with you, there are not enough staff, they definitely need more staff." A relative told us, "I visit regularly, I come in to assist [relative] to eat. There never is enough staff, they are rushed off their feet. It is very busy here, but they all do their very best."
- A staff member told us they were usually short in the afternoons because one staff member usually finishes at 1.45pm and the well-being staff member leaves at 4pm, "This puts pressure on the remaining staff, we are unhappy because we can't help residents, staff are leaving because nothing is organised, when [name] is crying we don't have time to support them."
- The service had been experiencing a high level of unwitnessed falls and other incidents. These would be additional factors to consider when determining staffing levels.
- We observed communal lounges unsupervised at key times, particularly late afternoon, with people trying to get up out of their chairs.
- A person became increasingly noisy, shouting out for attention. Staff members spoke with them briefly as they passed through the lounge. In these moments they settled. On one occasion they were given a cup of tea, but no assistance was offered. No meaningful or longer lasting interaction took place because the staff were all busy attending to others. Their anxiety and stress continued to increase, and they began to try to

stand up, they were unable to mobilise independently. They had spilt their tea and the floor was wet and slippery. We had to intervene and request assistance for this person.
● There were not enough staff to ensure people were consistently monitored and kept safe.

This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing risk, safety monitoring and management
● People were not protected from the risk of harm due to a failure to assess and manage risk effectively.
● Initially 2 communal rooms were in use for people to sit and dine in but when we returned during our inspection the registered manager had changed the use of the rooms into one large sitting room and one large dining room. They were unable to give a rational for the move.
● Moving everybody into one communal area heightened people's anxiety and stress more because everyone was together, unoccupied and agitating each other.
● A person was slipping out of their chair unnoticed; people were shouting at others to "shut up" and another person threw over their table causing crockery and a glass to crash to the floor. The lounge was unsupervised, and inspectors had to summons assistance.
● Observations of staff moving and assisting people identified poor practice. A staff member together with an inexperienced, untrained new staff member assisted a person to transfer from a chair into a wheelchair, incorrectly by pulling them up from under their arms. This is not safe practice for both staff and for the people involved and a bad example for new staff.
● People were transferred in wheelchairs with no footplates exposing them to the risk of injury to their feet by entrapment. Some staff did not always protect people's legs during a transfer and previous leg injuries were visible.
● A named and an unnamed rollator walking frame had worn ferrules exposing the metal frame. This posed a potential trip hazard. The registered manager confirmed the ferrules were not routinely checked.
● We had concerns about staff accommodation located in the attic rooms on the second floor of the premises, which could impact on the safety of people using the service. We requested the fire safety and rescue service to visit the service to check our concerns. They informed us the estates manager had carried out a new fire risk assessment on the staff accommodation since our inspection which had identified areas that required some remedial work, which they confirmed was in hand. Subject to the work being completed, the fire safety was satisfactory. The estates manager had also initiated action to improve the living conditions for staff.

This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Not all staff understood safeguarding principles or were confident in raising any issues or concerns. A new member of the management team did not know where the safeguarding policy was, said they had not read it and confirmed they did not know how to raise an adult safeguarding alert. This meant if they were the most senior person on duty, they would not be aware of the process to follow to safeguard people in a safeguarding situation.
● Following a sexual safety incident, the risk posed to the person and to others had not been assessed and there were no recorded support planning arrangements in place to minimise the risk and keep people safe.
● The provider did not have a sexual safety policy in place to guide staff in capacity, consent and sexual relations and how to protect people from incidents triggered by sexual disinhibition or other features of a person's mental health or dementia.

● Reviews of safety events needed further development to include a pro-active investigation to identify what went wrong, and why. This would ensure lessons were learned from them and appropriate measures put in place to prevent reoccurrence and embed good practice.

The regional operations manager gave us assurance the provider would be addressing a sexual safety policy and they arranged for the providers trainer to deliver training to staff in sexual safety in November 2022.

Preventing and controlling infection
● Cleanliness and hygiene were not being maintained in the kitchen. The cooker, extractor fan, fridges, storage areas and work surfaces in the kitchen were dirty and unhygienic.
● Infection prevention and control (IPC) audits had not identified areas where there were potential risks to cross contaminate and harbour bacteria. Such as cracked plastic menu holders; overlay tables with peeling laminate, dirty light pullcords, a build-up of dust and rust behind radiator covers, clean linen baskets stored on the floor and wet mops in buckets.
● People were not supported to wash their hands before meals or offered wet wipes.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider's infection prevention and control policy was up to date.

Following our visit, the provider's estates manager arranged for the kitchen to be deep cleaned.

Visiting in care homes
● Visiting arrangements were aligned to government guidance on visiting in care homes.
● We observed visiting taking place throughout our inspection. Relatives told us they visited regularly.

Using medicines safely
● People received their medicines as prescribed, in a safe and supportive way.
● Staff were trained and assessed as competent to administer medicines safely.
● There were systems in place to help ensure medicines were managed safely, to detect errors and take prompt action if errors were found. However, we found a medicine administration record (MAR) had been transcribed incorrectly by a member of the management team which meant the person it related to was placed at potential risk of overdose. This was immediately pointed out to the care team leader to address.
● People had their prescribed medicines reviewed by their GP to ensure they remained safe and effective.

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. 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 living at Memory House were at different stages of their dementia ranging from early onset to advanced stages. There was no plan about how the service would keep up to date and develop positively in this area to ensure the care provided was appropriate and reflected best practice. For example, sexual safety, engagement, stimulation and occupation.
- Assessments of need did not consider the full range of people's diverse needs. They did not identify people's strengths and the type and level of support they needed to meet their needs.
- Staff had a limited understanding of how dementia affected people in their day to day living. Appropriate strategies were not in place and staff did not know how to promote and maintain individual's interests and independence for as long as possible.

Staff support: induction, training, skills and experience

- Staff were not provided with a planned and structured induction programme in line with the providers policy to orientate them to the service. A new staff member, with no previous experience in care, was left standing around on their own for most of their first day. They had not been assigned a mentor nor had they received an induction itinerary or any relevant training. This did not promote a supportive and inclusive working environment or ensure they were equipped with the basic skills needed for their role.
- A staff member promoted to a management position had not received an induction to their new job role to give them a basic understanding of the role and responsibilities.
- Staff had completed e-learning in core subjects needed to do their job. However, a more comprehensive learning and development plan was needed to enable staff to develop the skills and expertise they needed to carry out their roles effectively.
- Staff lacked skills in person centred care, engaging with people in purposeful activity and responding effectively to the wider aspects of people's dementia related needs including communication, unsettled behaviours and end of life care.
- End of life care planning showed staff did not have the skills and confidence to have a meaningful conversation with people to help prepare and inform an end of life plan.
- Some staff had 'champion' roles. A champion is regarded as an internal expert on a subject matter who supports the wider staff team to deliver best practice. However, there was no additional training and support provided to enable staff to develop their knowledge and specialisms linked to their role or the needs of people they cared for.
- During an induction and probationary period, a new staff member should receive structured support and supervision. The service experienced a high turnover of staff with many new staff. Some had no previous

health and social care background and/or were recruited from overseas whose first language was not English. Probationary reviews were not consistently completed and support systems were poor.
● The concept of supervision was not recognised or understood by some staff. Supervision's were not regular enough to provide the level of on-going and effective support new and/or inexperienced staff needed, and to create a positive workplace. Supervision records were brief and failed to demonstrate how staff were being effectively supported.

The provider's failure to fully support and develop staff, placed people at risk of not having their needs met effectively. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The regional operations manager acknowledged they "should have prioritised [name] induction better" and they will ensure they "will restart induction afresh".

Adapting service, design, decoration to meet people's needs
● Improvement was needed to adapt the service in relation to design and decoration to meet people's needs and ensure best use of space. Such as colour, lighting, points of interest, sensory and quiet areas and assistive living technology.
● The premises had a small conservatory facing the sea and favoured by a few people. There were no blinds to protect people from the heat of the sun or the brightness which can be uncomfortable for people with ageing eye conditions. One person complained to us, "It's very hot in here".

The providers estates manager told us they would immediately seek a form of shade for the windows to protect people from the heat and brightness of the sun, but not obscure the view.

Supporting people to eat and drink enough to maintain a balanced diet
● People had choice and access to enough food and drink throughout the day and night. We received a lot of positive feedback from people about the food.
● People's weights were monitored well, and people's weights were maintained.
● Staff were aware of people's dietary needs and any support they required to eat and drink.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Management and staff worked with other healthcare professionals to ensure people received the support they needed to meet their needs.
● When we asked a staff member if there was anything, they felt could be improved they replied access to dental care.

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.
- The staff we spoke with told us how they tried to promote and encourage people to make choices about their day to day needs.

Inadequate

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 good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The service was not well led. There was a failure to recognise and identify emerging risk to people's health, welfare and safety.
- Audits and checking systems were not robust, operated effectively or scrutinised for accuracy and completeness. For example, the registered manager had signed off a health and safety audit on 30 September 2022 which stated the 'kitchen clean, orderly and cleaning schedules completed'. This was contrary to our findings.
- Flash meetings are a way to bring everybody together for a short time each day to share key information and concerns. However, records were poorly completed with no record of follow up actions from one meeting to the next. Issues including the kitchen requiring a deep clean, wheelchairs not being used properly, and people not being provided with wet wipes at mealtimes were all raised at the flash meeting held 9 August 2022. The flash meeting was ineffective because no action had been taken to address these issues.
- Observation showed there was no effective leadership to oversee and direct staff on each shift, provide an effective role model and identify poor practice. Staff did not have the skills and support they needed to support people living in the service.
- The management team and the provider were not robustly checking staffing levels were appropriate, to assure themselves and other agencies they had enough staff with the right skill mix to meet people's physical and emotional needs and keep them safe.
- The staff rotas for the 12 weeks preceding our inspection showed new staff from overseas were routinely working 12 -13 hour shifts five times a week consecutively. This can have an increased risk for reduced performance and patience, and fatigue related errors. Whilst staff have the choice to opt out of the 48-hour week, limits still exist due to health and safety considerations.
- The staff rotas did not diarise term dates to demonstrate working hour limitations for overseas students. It was unclear how this was being monitored.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There were no clear set of values, aims and aspirations for the service which staff could follow or be a part of. Staff did not understand the concept of values and more senior staff were not aware of them. The registered manager told us values were covered in staff induction, but they could not tell us what they were.
- The service did not promote a person-centred culture. The provider's established systems failed to assess

whether the home provided a positive, person centred culture.
● The low number of staff influenced the quality of care people received. Care was delivered with a task based approach and people were not supported to maintain their interests and independence.
● There was evidence of some good group activities facilitated by the wellbeing co-ordinator, but these were not suitable for everybody, particularly people with limited communication and/or elements of cognitive loss which meant that some individual social needs were not being met.
● Whilst the provider's 'forget me not' scheme encouraged staff to interact with people at least 4 times a day, the digital entries gave no indication of the type, duration and quality of interaction delivered or what impact it had on the person's wellbeing.
● Staff did not consider if people were comfortable or wanted to mobilise or have a change of scenery. People who had legs bandaged or had swollen feet were not encouraged to elevate them or given a stool to prompt them to do so.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Management and the provider were not assessing everybody's experience of care and support to see if they could be improved upon in any way.
● Resident meetings were attended by people who were able to verbally communicate well with staff, their voice was being heard. However, work was needed to explore experiences of people with more complex needs and how involvement in their care was promoted.

Working in partnership with others; Continuous learning and improving care; 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 local authority had concerns about the increased number of safety events at Memory House, including unwitnessed falls. We found over the last nine months there had been 51 falls in total from which 26 people sustained injuries.
● Falls were reviewed on an individual basis and each month. Incidents of falls were not analysed fully to identify trends and themes for the whole home and reduce likelihood of falls occurring. Low staffing levels were not considered by management as contributing factor.
● The provider produced a quarterly bulletin of lessons learned from complaints, adverse events and safeguarding concerns across their services. The June 2021 bulletin highlighted a high level of unwitnessed falls resulting in injury experienced across their services. The potential root causes were not shared but the outcome for improvement was falls prevention and management training for staff. Staff at Memory House had completed the falls e-learning training however this did not appear to have reduced falls.
● There was no evidence to demonstrate the service had engaged in local and national forums or development groups which would assist in gathering best practice knowledge to support improvements in the service, for example dementia care and end of life care.

This is breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2004 (Regulated Activities) Regulation 2014

● The management team were receptive to our feedback and acknowledged our findings. Some areas of concern were addressed immediately following our inspection.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way to meet people's needs and reduce risk to their health safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Oversight was inadequate and systems in place to monitor the quality and safety of the service were either inadequate or operated ineffectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Failed to ensure recruitment checks were complete to help protect people from unsuitable staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Failed to ensure there were sufficient numbers of suitably trained, skilled and competent staff deployed to meet people's individual and specific care and support needs effectively and safely.