Richmond Fellowship (The)

Moor View

Inspection report

20 Georges Square
Nursery Lane
Halifax
West Yorkshire
HX3 5TA

Tel: 01422368716
Website: www.richmondfellowship.org.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Moor View Care Home is a residential care home that was providing personal care to six people with mental health needs. The service is registered to provide care to up to 17 people.

People's experience of using this service and what we found
People were not always safe. Medicines were not always managed safely and staff did not feel adequately trained to manage medicines. There was evidence of staff working outside the registration of the service in relation to administration of medicines.

Some staff lacked confidence in developing and understanding risk assessments.

Not all staff understood how the emergency call system worked and staff had failed to report issues with the system.

Staff had not been provided with all the training they needed to carry out their duties and were not always supported in their roles.

Staff followed the provider's COVID-19 policy and infection and protection government guidelines.

There was a lack of effective and consistent management of the service. Staff did not always feel supported by the management team.

The provider's systems for assessing and monitoring the safety and quality of the services provided were not effective in identifying shortfalls and improving the service.

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 23 January 2019). At this inspection we found breaches of regulation 9 (Person centred care) and regulation 17 (Good governance).

Why we inspected
This inspection was prompted in part due to concerns received about management and safety. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led. No areas of serious concern were identified in the other key questions. We therefore did not inspect them. Ratings from the previous comprehensive inspection for those key questions were used in calculating the overall rating at this inspection. The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

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

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.

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 breaches in relation to safe care and treatment and good governance.

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.

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 of 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Moor View

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
The inspection was carried out by three inspectors. Two inspectors visited the service during the evening and another inspector spoke on the telephone with staff working at the service.

Service and service type
Moor View 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 did not have a manager registered with the Care Quality Commission. A registered manager along with the provider is legally responsible for how the is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. The visit to the service was made during the evening.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We spoke with staff involved with the service from the local authority and Clinical Commissioning Group (CCG).

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.

During the inspection
We spoke with two members of support staff during our visit to the service and five members of support staff on the telephone. We spoke with one person who used the service and reviewed a range of records. This included people's risk assessments, care records and multiple medication records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at a number of records sent to us by the provider including training data, staffing records and quality assurance records.

Inadequate

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 now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

● Staff did not always make sure risk assessments in relation to self-administration of medicines were followed. For example, one person's self-administration risk assessment stated the person was not self-administering but their related support plan stated they did self-administer. A recovery worker said it was not self-administration as they were observed by a member of staff. We saw this did not happen when the person administered their medicine during our visit.

● The service is not registered to provide nursing care. However, we saw a member of staff had administered a prescribed injection.

● Protocols for administration of medicines prescribed on an 'as required' (PRN) basis did not always include sufficient detail to support safe administration.

● A member of staff responsible for administering medicines told us they had to "make judgements" about administering PRN medicines and said they were "out of their depth" in relation to this.

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

Assessing risk, safety monitoring and management

● Staff were unsure about the call system in the service. We saw staff were not carrying the mobile phones which sounded an alarm if a person called for help. When we tested the system during our visit, we found it was not in full working order with only one of the three mobile phones working. This meant staff would not be able to respond to emergencies. We raised this with the area manager following the inspection. They confirmed they had taken immediate action to address the issue but also indicated that staff had known about the fault and failed to report it.

This further contributes to the breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Personal risk assessments were in place, but these were lengthy and not all staff we spoke with were confident in using or developing them. One staff member said they were responsible for developing them but had not had any training in this area.

● Staff were unsure about what actions should be taken in relation to one persons physical health and we did not see a risk assessment in relation to this.

Staffing and recruitment

● All of the staff we spoke with voiced concerns about staffing in the service. Some of the concerns had been addressed by the provider after intervention by the Clinical Commissioning Group (CCG). However, staff gave us examples of being "frightened" when working and not getting support when they raised their concerns.
● Some staff raised concerns about the induction and training of staff. One said the staff team were not skilled enough to support people safely.

This further contributes to the 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
● The manager maintained a record of safeguarding events including the actions taken to mitigate the risk of the incident reoccurring.
● Not all of the staff we spoke with were sure about the actions they should take if they thought somebody was at risk,

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● 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 was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

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 the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. 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; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

At the last inspection there were repeated failings in the management and quality of the service despite changes in the management team. This was a breach of Regulation 17 (Good 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.

- There had been a further change of management team since our last inspection. The previous manager had left the service and a new management team, including manager, service manager and area manager had been introduced within the four months prior to the inspection.
- There was a lack of evidence of systems in place to monitor quality in the service. Some auditing had been planned and postponed but there was no evidence of any provider oversight since the last inspection.
- Some of the staff we spoke with were unclear about their roles and unclear about the roles of the new management team. One member of staff said they thought the management of the service was "up in the air".
- Staff did not always feel listened to and some felt communication from the management team was not always appropriate.
- One member of staff told us they felt "bullied" and unsupported by the management team.
- A service user feedback audit dated as completed in September 2020 did not include any feedback from people who used the service. We did not see any evidence of people's views being sought and used to develop the service.
- Feedback from the local authority and CCG indicated the service had made changes which had not been discussed or agreed with them as commissioners of the service.

This evidence represents a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

● Some staff told us they did not feel as though they had received the training they needed to do their jobs safely and effectively. This was particularly in relation to supporting people's mental health needs to empower people in the recovery and rehabilitation model of the service.
● The area manager had contacted the Care Quality Commission to inform about changes to the management structure and to inform about notifiable events within the service.

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 Medicines were not managed safely Staff had not received the training they needed to support people safely. Staff had failed to recognise and report failure of the emergency call system