Cristal Care Limited

Rother Valley View

Inspection report

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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 caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Rother Valley View is a residential care home providing personal care to 6 people. The home consisted of 6 self-contained flats. People had access to a communal kitchen, dining and living room and large gardens.

People's experience of using this service and what we found
Significant shortfalls were identified in the governance of the service. Some systems were in place to check the service was working to the provider's expected standards. However, where the checks had been completed, they were not effective and did not identify the concerns we had raised as part of this inspection. There was a lack of provider oversight of the standards at Rother Valley View.

People were not always kept safe. We found concerns with the safe management of risk for areas including people who were at risk of choking and ingesting hazardous substances and environmental concerns.

Staff were not always recruited to ensure people were safe.

Infection control concerns were identified in relation to staff not consistently wearing PPE.

There was a lack of analysis of accidents and incidents to ensure lessons were being learnt to drive improvement.

Staff were not suitably trained to meet people's needs

People's health needs were not accurately recorded and updated.

Feedback had not been sought to drive service improvement and development.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support:
• People's choice was not maximised, and they could have been better supported to develop more control and independence.
Right care:

• Care was not always person-centred and promotes people's dignity, privacy and human Rights.
Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff didn't ensure people always lead confident, inclusive and empowered lives.

The provider set out an action plan on how they intended to improve the service moving forward.

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

This service was registered with us on 19/10/2019 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about safe recruitment. A decision was made for us to inspect and examine those risks.

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

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

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 person centred care, safe recruitments, safety, staff training, supervision and management of the service.

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

The provider took immediate action looking at the risks we had highlighted during the inspection.

Follow up
We will request an action plan for 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 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 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 caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Rother Valley 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 two inspectors.

Service and service type
Rother Valley 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with one person who used the service and five relatives about their experience of the care

provided. We spoke with nine members of staff including the provider, registered manager, and support workers. We carried out observations of care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included two people's care records and medication records. 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 policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who visit the service.

Inadequate

Is the service safe?

Our findings

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management: Learning lessons when things go wrong

- Risks associated with people's care and treatment had not always been identified and managed safely. For example, one person was at risk of choking and they were not supported in line with recommendations from the speech and language therapist (SALT).
- People were not sufficiently protected from harm. Risk assessments had not identified shortfalls we found on inspection or were not being followed. We found household substances such as Dettol and surface cleaner left unlocked despite there being an identified risk of ingesting these type of products.
- Accidents and incidents were not effectively monitored and analysed to ensure that actions were taken to reduce the risk of incidents happening. For example, according to health records one person had sustained an injury as a result of a bang to the head. However, their care plan had not been updated with details on any preventative measures.
- Lessons were not being learned and improvements were not maintained or sustained.
- Environmental checks in relation to fire safety, gas safety and electrical safety were in place, however at the time of the inspection the electrical equipment was overdue being PAT tested for over six months.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. The provider was failing to ensure they were doing all that was reasonably practicable to manage and mitigate risks. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Documentation of the administration of medication we reviewed was not clear and it led us to believe that one person had been given too much medication. The provider was not able to provide assurances that the person had not been given too much medication and a safeguarding alert was raised.
- Medication systems were in place; however, people didn't always receive medication as it was prescribed. Medication was not always recorded appropriately. Therefore, it was not possible to effectively audit the systems to ensure medicines were appropriately and safely administered.
- Medication prescribed on an 'as required' basis, (PRN) were not always recorded appropriately when it was administered. We saw some PRN protocols did not detail adequate information for staff to determine how to administer these medicines. Therefore, it was not clear if PRN medicines were being given as prescribed.
- No records of what medicines were in stock were being made, so discrepancies in administration were not being identified.

The provider had failed to manage people's medicines safely and therefore is in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● We were alerted before the inspection that the provider had not sought adequate assurance around the character and suitability of staff. We identified one staff had been employed prior to all safe recruitment checks being carried out. This meant that people were left vulnerable to potential abuse.

●The provider took action to address this concern and put checks in place to ensure the recruitment process was being followed for all staff.

We found no evidence that people had been harmed however, systems were either not always followed relating to safe recruitment. This placed people at the risk of harm. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated

Systems and processes to safeguard people from the risk of abuse

● Systems and processes did not operate effectively to report allegations of abuse.

● Staff had received training in safeguarding but did not always recognise and respond to safeguarding incidents appropriately.

● Following our inspection, we asked the provider to make three referrals to the local authority safeguarding team.

There is further information relating to this in the well led section of this report.

Preventing and controlling infection

● Staff were not always using Personal Protective Equipment [PPE] correctly to reduce the transmission of infection. Throughout our visit a member of staff on numerous occasions removed their face covering. This is contrary to the guidance currently in place.

● We found some areas of the home were not well maintained so could not be effectively cleaned. For example, untreated wood in the kitchenette. We also found storerooms cluttered and unorganised, with many items thrown on the floor. These could not be effectively cleaned.

● The infection, prevention and control audit tool used by the provider had not identified all the concerns that we found on inspection so was not effective.

We have signposted the provider to resources to develop their approach.

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff were not suitably competent or skilled. The provider's training plan showed over half of staff had not completed a NVQ qualification, or equivalent, in health and social care. This includes the Care Certificate which is a set of 15 standards that sets out the knowledge, skills and behaviours expected for specific job roles in the health and social care sectors.
- Staff told us that they lacked knowledge and confidence around how to support people with behaviours that may challenge others.
- Staff had not received any training to support people with dysphagia (swallowing difficulties) despite there being an identified risk to people of choking. 24 out of 32 staff had not received training in first aid, and over half the staff were not trained in epilepsy, despite one person having epilepsy.
- There was a lack of staff supervision and competency observations to check staff had the relevant skills, experience and ability to support people. The provider's policy set out timescales that staff should receive supervision and appraisal and these timescales had not been achieved.

The provider had failed to ensure there were skilled and experienced staff deployed to meet people's needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff said they did feel supported by management and were able raise anything with managers. One said," [Registered manager] is approachable and supportive, he's a nice man, sometimes juggles too many things".

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Supporting people to eat and drink enough to maintain a balanced diet

- The quality of information detailed in care plans did not meet people's needs. For example, we saw one person had specific needs around eating and drinking but there was no available care plan.
- Behavioural support plans were not sufficiently detailed to ensure people were supported in line with best practice guidelines. They were not regularly reviewed to ensure they contained the most up to date guidance on how to support people.

Staff working with other agencies to provide consistent, effective, timely care

- Health action plans for people lacked detail. Accurate records relating to health were not maintained. This

meant people's health needs could be overlooked.
● Relatives had raised concerns about staff attending health appointments unprepared and unable to handover information about their relative's health and wellbeing.
● Records were not always completed on what people ate and drank so it was difficult to tell if people had been supported to eat and drink in line with their assessed need. One person was assessed as needing to gain weight by being given a fortified diet. They had gained weight, however there was no record to show food had been fortified as recommended.

The provider failed to provide person centred care and support meaning that people's needs, and preferences were not met. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Mealtimes were flexible, and people made individual choices. We saw one person enjoying Indian starters for their lunch and they chose to sit and eat outside in the garden.

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.
● There was a record of DoLS applications that had been received and followed up where necessary.
● Staff had awareness regarding the mental capacity act.

Adapting service, design, decoration to meet people's needs
● The environment was decorated in a pleasant way and it felt homely.
● There was large enclosed garden available with a greenhouse and outside shed which had been adapted into a small activities area.
● People's rooms had been personalised with items meaningful to them.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

●People were involved in some decision around their care but not in others.

● Staff were kind and caring and positive interactions were seen. We observed one staff member supporting a person who was quite agitated, they were kind, caring and patient with the person. However, we observed people being spoken to like they were children which was disrespectful.

● When staff were supporting people on a one to one basis, other staff would step in and get involved which appeared to distress the person and showed a lack of insight into the person's needs.

● Relatives gave mixed feedback on their loved one's care. One relative said, "When I have visited, I have only ever seen one staff member doing something with a person. I know some go for walks and go home to see parents but staff on site just don't engage with people. I have looked at [relative's] notes and they don't say anything. Staff don't do anything to encourage [relative] to come out of their room and staff are fearful of going in." Another said, "[Person's name] receives really good care there, we have video chats. I have been in the home a few times but not much over the past year due to pandemic. My relative always looks happy when I communicate via the video, and their facial expressions always lead me to believe they're happy and content there."

Respecting and promoting people's privacy, dignity and independence

● Privacy and dignity were not always maintained. We found that personal and sensitive information was not stored in line with the Data Protection Act.

● All staff had access to the manager's office and care plans were stored unlocked in a communal living area.

● People were helped in a discreet and dignified manner. However, we noted occasions during the inspection where people's privacy and dignity were not dealt with as expected.

● People's preference to have time alone in their rooms was respected and staff asked permission to come into people's flats, prior to entering.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● There was a lack of meaningful activities available. We were told by one relative, "People are bored and this leads to behaviours. Staff used to try but they don't now. [Name] has got worse since he has been at Rother Valley View."
● There was a lack of meaningful activities available to people. One person spent the full day in their flat and we didn't see them come out or being encouraged to take part in any activities which could have prevented social isolation.
● There were no records to show any outcomes and goals that people had achieved or were working towards achieving.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Information was available to people in accessible ways. One person had signs and pictures in place to use to enhance communication and mirror learning from school.
● Support plans contained information on how people communicated but needed more detail to assist and instruct staff on how to best meet people's needs, specifically when they presented behaviours that may challenge others.

Improving care quality in response to complaints or concerns
● The provider responded to complaints. They had a record of complaints and the outcome to the complaints in line with their policies and procedures.
● Relatives felt able to complain. One relative said," I have met the manager a few times and I think I could approach them if I needed to". Another said, "I feel that I can speak with manager and staff about anything I need to."

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.

This is the first inspection for this newly registered service. This key question has been rated 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; Continuous learning and improving care

- The provider had poor oversight of the service and demonstrated a lack of awareness of some of the issues which we highlighted at this inspection.
- The management of safety, risk and governance had not been effective. We identified concerns about people's safety during the inspection.
- Confidential and sensitive information was not stored in line with the Data Protection Act.
- Quality assurance systems were not robust, there were some audits completed but they had not identified shortfalls or taken action to address shortfalls. This meant the service had not been operated effectively and had failed to identify concerns.
- Medicines audits had not identified medicines errors, lack of stock check and a failure to administer medicines as prescribed.
- Lessons were not being learnt from accidents and incidents to ensure service improvement.

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

- The provider had failed to identify accurate records relating to people's care were not being maintained, to ensure staff had access to consistent and accurate information about people's support needs. For example, they had failed to identify that there was a lack of information in care records, such as the support people needed.
- Suitable care plans and risk assessments were not in place. Plans for specific known health conditions were not in place to provide staff with knowledge of the person's condition and how to support them. We also saw that risk assessments for known risks to people were not in place, or not being followed. We were provided with some revised care plans following the inspection, which did show some improvement. However, they needed further improvement to ensure they provided enough guidance and detail for care staff members to support people, in the way they wanted.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider did not always fulfil their responsibilities to notify us of certain events such as allegations of abuse, and serious incidents. They were advised to update their knowledge of the regulations to include notifiable events. We found a number of incidents had not been reported which the provider notified us of retrospectively.

● Relatives felt that they had not always been informed of incidents in a timely manner.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Relatives, stakeholders and people using the service had not been asked to feedback on how the service was being run or what could be done better to drive improvements. The provider showed us that they had questionnaire available to send and plans to send them in the coming weeks.

●Feedback from professionals was that the service had not effectively worked in partnership with them to adopt or make strategies to improve.

The provider failed to ensure sufficient oversight to monitor the quality and safety of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection the provider gave us an action plan detailing what improvements they planned to make.

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 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to ensure people received care that was person centred and met their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Assessments of the risks to the health and safety of service users of receiving care or treatment were not always followed,reviewed or mitigated. Not all staff providing care and treatment had the competence, skills and experience to do so safely. Medicines were not always managed safely. Infection prevention and control procedures were not routinely implemented by staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider had failed to ensure safe recruitment processes were followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care	The registered provider had failed to ensure persons employed had received suitable and sufficient training and supervision to carry out the duties they were employed to perform.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to establish or operate robust systems or processes to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others, or the quality and safety of the services provided. The service did not routinely maintain an accurate, complete and contemporaneous record in respect of each service user or the management of the regulated activity.

The enforcement action we took:

We served a warning notice for breach of Regulation 17.