Runwood Homes Limited

Silvanna Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Silvanna Court is a care home providing personal and nursing care to up to 83 people. The service provides support to older people and people with dementia. At the time of our inspection there were 78 people using the service. The home is split over three separate floors, each with communal lounges and dining areas.

People's experience of using this service and what we found
Medicines were not always managed safely as some PRN (as required) medicines were given routinely without the appropriate records to identify the reason the PRN was given or the outcome. Risks were not always effectively assessed or addressed. There were not always enough staff on duty to support people safely. Accident and incidents were analysed but key information was often missing to ensure the analysis was effective. Staff were trained to recognise and respond to concerns of abuse. There were adequate infection prevention and control measures in place.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Care was not always responsive to people's assessed choices and support needs. People and relatives told us people were not always supported with their personal care needs in the way they wanted.

There were gaps in management oversight and systems for auditing at the service did not identify the concerns we found during the inspection. There was a new manager in post who was not yet registered with CQC.

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

The last rating for this service was good (published 6 July 2018). At this inspection the service has deteriorated to requires improvement.

Why we inspected
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.

We received concerns in relation to staffing levels, and people's personal care needs. As a result, we undertook a focused inspection to review the key questions of safe, caring and well led 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 requires improvement based on the findings of this inspection.

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

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 Silvanna Court on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 monitor the service and will take further action if needed. We have identified breaches in relation to safe care and treatment, staffing, dignity and respect and good governance.

Please see the action we have told the provider to take at the end of this report.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our well led findings below.

Silvanna Court

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
This inspection was carried out by three inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Silvanna Court 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. Silvanna Court 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 service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post. A new manager had started at the service and was in the process of registering with CQC.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 14 April 2022 and ended on 28 April 2022. We visited the location's on 14 April 2022.

What we did before 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 the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 10 people who used the service and five relatives about their experience of the care provided. We spoke with 12 members of staff including the regional director, manager, unit managers and care staff.

We viewed a range of records. This included 16 people's care records and multiple medication records. We looked at five staff files in relation to recruitment. A variety of records relating to the management of the service were reviewed. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection
We continued to seek clarification from the provider to validate evidence found. The Expert by experience contacted a further 16 relatives by telephone.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- People were not always receiving their medicines as prescribed. We found people were being given medicines prescribed as and when required [PRN] regularly.
- Records showed four people were prescribed medicines to take as required when anxious or distressed. However, they were having these medicines regularly without reviewing with medical professionals. There was no documentation to support staff to use other therapeutic techniques prior to these medicines being administered. Records had not been kept to identify the effectiveness of the medicines given. .
- One person was prescribed a medicine PRN for sleep problems, again this had been administered regularly. There was no PRN protocol in place and the person's daily records did not identify any issues with sleep that would lead staff to administer this medicine.
- We were not assured the service was always following the least restrictive methods prior to the administration of PRN medicines . There was limited detail about why these medicines were being administered regularly, and if this was in the person's best interest.
- PRN protocols we saw were basic and did not provide staff with any guidance about how these medicines should be administered and why.
- We reviewed medicine audits from January 2022 to March 2022. There was no evidence the concerns we had identified had been picked up by the management team or the provider.
- We requested a safeguarding alert should be raised regarding the people being given medicines not in line with the prescriber's instructions and people's distressed reactions being managed by medicine routinely rather than evidencing any other therapeutic staff interventions that could be tried first. Following the inspection these safeguards were raised and the provider informed us they were carrying out a full investigation.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Risks to people were not always effectively assessed or addressed. Where risk assessments had been completed guidance for staff was not always detailed or clear.
- One person had been admitted back to the service from hospital with a catheter. The type of catheter was not recorded on their records and not all risks were highlighted. There was minimal guidance for staff to follow to ensure risks were being mitigated. The fluid records were inconsistent which meant output records were often low in relation to how much fluid the person had drunk.
- There were some gaps and inconsistencies in people's monitoring information. For example, repositioning charts for two people with pressure ulcers contained significant gaps. This meant we could not be assured

that skin care for people was appropriate.
● Where people had been identified as having distressed reactions, there was no clear guidance for staff to safely manage these occasions. Minimal information was recorded about potential triggers or guidance on how therapeutic methods could be used.
● ABC charts were in place for some people (An ABC chart is an observational tool that allows the user to record information about a particular incident. The aim of using an ABC chart is to better understand what the distressed reaction is communicating.) however, there was very little information about what may have triggered the incident. The ABC chart recorded that high-level intervention was required but did not explain what this high-level intervention was.
● Accidents and incidents were recorded and analysed. However again information was inconsistent. For example, in March 2022 there were two occasions where the location of the fall had not been recorded, and another occasion where one person had been pushed over by another person. Staff recorded this had not been reported to the relevant safeguarding authorities or CQC. We were not assured this analysis was looking in detail at themes and trends. We asked the manager to re-review these accidents and incidents.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other feedback we received was positive. One relative told us, "Yes I do think [person] is safe, the staff have been amazing. When [person] first went there they were very anxious and difficult to the staff, but they were so patient to [person] and to us. [Person] absolutely loves it there, they do have a good understanding of [person] and they know their needs. Knowing they are safe and happy makes a huge difference to our lives."
● Another relative said, "[Person] seems to be happy there, they seem to be okay. They have put on weight."

Staffing and recruitment
● We received mixed feedback from people and relatives about the availability of staff. One person told us, "I find it insufficiently staffed there is hardly any staff, if I pull my cord, I can wait anything from 10 minutes to 30 minutes." A relative told us, "There is definitely not enough staff and [person] does not get hardly any 1/1 time." Another relative said, "A couple of times I have taken [person] to the lounge and there was no one there which is very concerning for me. I couldn't find anyone to tell that I was taking [person] out, so we had to tell someone downstairs at reception. There should always be someone here."
● Relatives also expressed concerns they were often left waiting at the door at weekends to be let in. One relative told us, "I think the staff there are really good, but at the weekends it is different. During COVID-19, we would stand outside and ring the bell and waited for half an hour to get let in, we gave up after 30mins. It is hard to get them to answer the door and answer the phone."
● Staff we spoke with also expressed concern in relation to staffing levels. One staff member told us, "There are definitely not enough staff here. We are always rushed off our feet and don't have time to take people to the toilet, they have to wait. We don't have breaks anymore." Another staff member told us, "Sometimes there is not enough staff. When we are short of staff it's hard to make sure there's always someone with people and doing basic things like getting them to bed. I think managers know."
● During the inspection the observations of staffing levels were mixed, whilst on two floors supervision and deployment was appropriate, on the middle floor the inspector had to request staff to answer the buzzer on two occasions and the communal area was left unsupervised.
● Staffing levels also impacted on people's care needs and people told us they did not always receive baths or showers that met their preferences. A staff member told us, "Once a week they have baths or showers. We can't offer showers every day, that's too much."
● The provider used a dependency tool to calculate staffing based on need. However, when we looked at

this analysis, we were not assured the information used was always accurate. One person who was regularly administered medicines due to distressed reactions that might lead to them harming themselves or others was assessed as a low risk in January 2022, February 2022 and April 2022. The dependency tool we looked at in December 2021 recorded their dependency level as medium and when we reviewed their care plan, we found that an individual dependency assessment for this person had not been completed in December 2021.
● Systems were in place to recruit staff safely. However, we identified some gaps that included staff with only one reference, one staff member had a character reference from their family member and one staff member did not have full work history.
● The service had employed one staff member who was under the age of 18. The providers policy stated , "Young employees are those above school leaving age, but under the age of 18 and 'Runwood Homes does not permit young people to work in excess of eight hours per day and they are subject to a maximum working week of 40 hours." We found two occasions on recent rotas where this staff member had worked over eight hours.

Insufficient staff were available which placed people at risk of harm and delayed care. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other relatives we spoke with were positive about staffing levels at the service. Comments included, "They have sufficient staff, the care does not dwindle because of shortage. The staff cope really well", "I am sure they could do with more, there are times when you feel they could do with another pair of hands. Staff cope, it does not affect my [family member] ", "I think they are very busy; they work their socks off really."

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 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.

● We were somewhat assured that the provider was using PPE effectively and safely
● During the inspection we observed staff wearing PPE incorrectly.

Visiting in care homes
● The provider was facilitating visits for people living in the home in accordance with the current 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● 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. Any conditions related to DoLS authorisations were being met.

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.

At our last inspection we rated this key question outstanding. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

- The level of staffing had an adverse impact on people's dignity. People, relatives and staff told us people were not always supported with personal care in a timely way.
- One person said, "I get up in the morning, sitting in the nude, they give me a hot flannel and a very quick wash. Since I been here, I think I have had two or three showers and one bath, I would like more but they do not have the time to do it." A relative said, "The issue is going to the toilet, occasionally pads are full, and we can smell it as soon we walk into [person's] room."
- Staff also commented they did not have enough time to support people with personal care. One staff member told us, "It is really embarrassing for them and especially [person] as they are always soiled but we just don't have enough of us to take [person] to the toilet and I feel sad for them."
- Interaction between staff and people who used the service was task-orientated, whilst during the inspection staff were supervising people in communal areas there was minimal conversation. A staff member told us, "We do not have time to sit and chat. We try to chat in happy hour but that is really the only time we have."

People's privacy and dignity was not always considered, and their preferences respected. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some people were offered the opportunity to sit in the garden during the inspection and staff supported people with this.
- Despite the lack of interaction during the inspection we did receive some positive feedback from people and relatives. One person told us, "I have been here for years. They are very good the staff here."
- A relative told us, "Yes they are caring and compassionate, they tell me how [person] is and tell me how they have comforted them when they are upset. Staff come in and have a chat, they build up the relationship. They are compassionate and understanding." Another relative said, "100% caring and compassionate, approachable with any issues we might have had and courteous, all friendly and polite."

Supporting people to express their views and be involved in making decisions about their care

- People were supported to decide their care needs and when appropriate, relatives were involved in the care planning process. One relative told us, "Yes I was involved initially in [persons] care plan with their wishes. I think there is a review soon." Another relative said, "When [person] first went there I gave them all

the details of what [person] likes. They [staff] have the time to spend the time with them. They have a shower every other day, they have full capacity, and they always look clean."

● During the inspection we observed staff offering people choices when supporting people with food and drink or what they wanted to do.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The last manager had left the service. The current manager had been at the service for a week. However, they had previously been registered at the service so were familiar with the home.
- The provider had quality monitoring systems in place; however, these were not always operated effectively. We identified shortfalls relating to the management of risk, staffing levels and medicines management.
- Analysis of falls and other incidents had not been conducted effectively as some relevant information had not been captured. This meant themes and trends of incidents could not always be identified to consider the prevention of risk.
- Dependency scores were not always accurate which meant staffing levels could not be calculated accurately.
- The provider had a home development plan in place that did identify shortfalls in the service, however most issues did not have a person responsible recorded or a date of completion and had not picked out all of the issues we identified during the inspection.
- The provider had failed to ensure a risk assessment was in place to support the recruitment of a staff member who was under the age of 18 years. This placed people at possible risk, the staff members personnel file also did not contain any supervision information and their hours worked was above the guidance recorded in the provider's own policy.

The provider did not have robust processes in place to monitor the safety and quality of the service. This demonstrated a 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There were areas where the culture of the service needed to be improved. We found concerns about how some staff interacted with people on the day of inspection. In most lounges the television was on and staff were present but there was little sustained conversation during our visit.
- Staff were positive about the arrival of the new manager. One staff member told us, "I feel better [new manager] is here, it was a little hit and miss. A manager constantly changing isn't always great." Another staff member said, "Managers are very good and listen."

● Some relatives were very positive about the service. One relative told us, "I get a real feeling of happiness with the staff, relaxed, it feels like a home, clean, it is bright and inviting and a sense of trying to help people have the best life they can. To see my [person] having a life with the friends they have and the activities they have, I go in and feel happy."
● Meetings were held for people and relatives. However, we received mixed feedback in relation to communication. One relative told us, "Yes we had all the social care meetings and reviews. We are always given the opportunities to say something, there are zoom meetings where we can say things as well." Another relative told us, "There are zoom meetings, able to make suggestions and have a word, the minutes are sent out at the end of the meeting, any concerns would be addressed." A third relative told us, "I don't know of anything like this."

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 understood their responsibility to be open and honest when things went wrong. Relatives told us they were contacted if there were any concerns. One relative said, "I feel that communication is good, [person] fell out of bed a few weeks ago and they phoned me immediately to tell me that they had fallen out of bed, there is now a pressure mat on the floor next to her bed.
Working in partnership with others
● The service had been working closely with the local safeguarding team to ensure they followed their procedures.
● Staff continued to work in partnership with health professionals involved in monitoring and providing care and treatment for people using 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 10 HSCA RA Regulations 2014 Dignity and respect People's personal care needs were not always met in a timely way which compromised their respect and dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems to monitor and mitigate risks to the safety and welfare of people using the service were not always effective. Medicines were not always managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes to monitor the safety and quality of service provision were not robust. Care records and monitoring charts had not always been completed fully and accurately.