Mavesyn Ridware Residential Home Limited

Mavesyn Ridware Residential Home Limited

Inspection report

Mavesyn Ridware House
Church Lane
Rugeley
Staffordshire
WS15 3RB

Tel: 01543490585

Date of inspection visit:
03 March 2021
04 March 2021

Date of publication:
27 August 2021

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
Mavesyn Ridware Residential Home Limited is a residential care home providing care to 12 people aged 65 and over at the time of the inspection. The service can support up to 21 people in one building.

People's experience of using this service and what we found
People continued to be at risk of harm as the registered manager and provider had not assessed and mitigated risks to people. This included risks in the environment of the home as well as risks associated with people's health and care needs.

Medicines continued to be managed unsafely which meant the provider could not be sure people got the medicines they needed, when they needed them.

People had not been protected from the spread of infection because suitable systems and processes were not in place.

People were not supported to have maximum choice and control of their lives and staff did not 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.

The registered manager and provider had not implemented systems that were effective in identifying improvements and ensuring changes happened when they were needed. This meant that people continued to receive care that was not safe.

The registered manager and provider had not complied with their lawful duties to notify CQC of required events and had not displayed their current rating at the service.

There were enough staff that had been safely recruited to support people. However, staff did not have the guidance they needed to support people safely.

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 inadequate (published 25 December 2020 with a supplementary report published April 2021) and there were three breaches of regulations.

At this inspection enough improvement had not been made and the provider was still in breach of those regulations with additional breaches of regulations.

This service has been in Special Measures since the last inspection. During this inspection the provider

demonstrated that enough improvements had not been made. The service continues to be rated inadequate. Therefore, this service continues in Special Measures.

Why we inspected
We received concerns about a lack of improvement since the last inspection and people continuing to be placed at risk. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We did not inspect the other key questions. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this 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.
The overall rating for the service remains inadequate.
You can see what action we took at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Mavesyn Ridware Residential Home Limited on our website at www.cqc.org.uk.

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 seven breaches at this inspection. These breaches relate to safe care and treatment, management and governance, consent, person-centred care, safeguarding people from unlawful deprivations of liberty, failure to display the most recent CQC rating and failure to notify CQC of required incidents.

We took enforcement action to cancel both the manager and the provider's registration with us.

Follow up
We will continue to work with the local authority, other professionals and stakeholders to monitor the service. We will continue to monitor information we receive about the service until we 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 remains 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?

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.

Mavesyn Ridware Residential Home Limited

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 an inspector and an assistant inspector.

Service and service type
Mavesyn Ridware Residential Home Limited 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 had a manager registered with the Care Quality Commission. 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.

Notice of inspection
This inspection was unannounced.

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 all of this information to plan our inspection. 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 three people who used the service about their experience of the care provided. We spoke with seven members of staff including the registered manager, deputy manager, senior care workers, care workers and a cook. Some people were unable to speak with us about their experiences so we observed how staff interacted with people in communal areas to help us understand the experience of people who could not talk with us. We spoke with two visiting professionals about their experience of working with the service.

We reviewed a range of records. This included three people's care records and multiple medicines records. We looked at two 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 and registered manager to validate evidence found. We held an online meeting with the registered manager, deputy manager and provider as the registered manager and deputy manager were unavailable on the days of the inspection. We requested additional evidence and documentation from the registered manager that was not available on the days of the inspection and we reviewed this. We spoke with two professionals who regularly visit 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 the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at continued risk of avoidable harm.

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

At our last inspection the provider had failed to ensure risks relating to the safety, health and welfare of people using the service were assessed and managed. This was a breach of regulation 12 (Safe Care and Treatment) 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 12.

● The environment was not safe for people because the provider had not kept up to date with required maintenance including electrical installation safety tests. There was also no legionnaires disease risk assessment and associated testing in place, which is a requirement in care homes to protect people from the risk of contracting legionnaires disease. This left people at risk of harm from living in an unsafe environment.
● The fire system had not been upgraded by the provider following recommendations given in a fire report carried out by an external company in December 2020. Although the fire alarm system was operational, it required upgrading and did not meet the latest safety standards required for care homes.
● Environmental risks had not been identified and suitably assessed to minimise the risk of harm to people. For example, several portable heaters were in use and were placed very close to people and armchairs. One person's coat was directly next to the heater and was hot to the touch. There was a risk of ignition and no action had been taken to minimise this risk.
● There was no system in place to ensure appropriate checks of the environment were completed therefore safety issues that we found had not been identified.
● People's risks were not always assessed, monitored and managed to ensure their safety.
● Some people were at risk of malnutrition and had lost weight. A dietician had advised they must be offered high calorie snacks to manage the risk of further weight loss which would be detrimental to their health. We found that people were not being offered the correct types of snacks and not being offered them often enough which meant they continued to be at risk of further weight loss.
● Some people were at risk of constipation. There was an escalation process where a medical professional should be contacted if the person had had no bowel movement for a certain number of days. We found this was not always followed and people continued to have no bowel movement for days or evens weeks with no medical advice or input sought. This put people at risk of constipation, associated health issues, pain and discomfort.

The above evidence demonstrated that people were placed at continued risk of harm through ineffective

risk management. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection the provider failed to protect people from the risks associated with the unsafe management of medicines. This was a breach of regulation 12 (Safe Care and Treatment) 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 12.

● Medicines continued to be unsafely managed with no improvement since the last inspection.
● There continued to be limited guidance for staff to assist them in administering covert medicine safely. Covert medicine is medicine which is 'hidden', usually in food or drinks. Care plans did not indicate what measures should be tried prior to resorting to giving medicines covertly and staff were unclear about the guidance and practice that should be followed to ensure people's rights were upheld when administering covert medicines.
● Covert medicines were being administered to a person yet the provider's own medicines policy and procedure did not cover the administration of covert medicines. This meant the provider had not ensured that staff had available guidance to follow.
● One person, who had dementia, was prescribed a course of antibiotics for an infection by their doctor. However, the person refused to take the tablets. The service contacted the doctor but when they did not get an immediate response. No follow up happened which meant the person continued to refuse the full two-week course of antibiotics, leaving their infection untreated with no further medical advice sought.
● Staff did not accurately record when medicines were administered and did not keep a full and accurate record of stock counts so we could not be assured people were receiving their medicines as prescribed.
● We observed a medicines trolley on the upper floor was left unlocked with the key in the lock for the duration of the two-day inspection. This meant the prescribed topical medicines inside were accessible to people who used the service, some of whom were living with dementia and were at risk of ingesting or accessing the topical medicines that were not prescribed for them.

The above evidence demonstrated that people were placed at continued risk of harm through unsafe management of medicines. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were not assured that the provider was taking all necessary steps to keep people safe from cross infection, especially during the COVID-19 pandemic.
● We were not assured that the provider was meeting shielding and social distancing rules because there had been no attempt to support people to socially distance. Chairs in the dining room and lounge remained directly next to and adjacent to each other so people were not given the opportunity or encouraged to socially distance which meant they were at increased risk of cross infection.
● We were not assured that the provider was using Personal Protective Equipment (PPE) effectively and safely. We saw multiple examples of staff not using PPE correctly including not wearing gloves or aprons when supporting people to eat. We also observed that staff did not wash their hands in between supporting people which increased the risk of cross infection.
● The provider's infection prevention and control policy was not up to date. Although the policy had been

reviewed in January 2021, it had not been updated or amended and made no reference at all to the COVID-19 pandemic or how the provider was keeping people safe and reducing the risk of people contracting COVID-19. This left people at significant risk of harm as there was not an up to date infection prevention and control policy for staff to follow.
The above evidence demonstrated that people were placed at risk of harm through unsafe infection prevention and control practices. This was 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

At our last inspection the provider had not ensured that care and treatment was provided with consent from the relevant person. Furthermore, the provider had not followed the principles of the MCA. This was a breach of regulation 11 (Need for consent) 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 11.

● 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).
● People's mental capacity to consent to their care and treatment had not been assessed when required.
● Covert medicines continued to be administered without a necessary assessment of the person's capacity being completed.

The above evidence demonstrated that the provider had failed to obtain consent from people and had failed to act in accordance with the MCA when people lacked the capacity to consent. This was a continued breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people had restrictions placed upon them such as bedrails and chairs which they were unable to get up from. The registered manager and provider had failed to assess people's capacity to consent to these restrictions and failed to apply to lawfully restrict people's liberty when this was required.
● One person had a DoLS authorisation in place in relation to administering their medicines covertly. This authorisation had a condition attached to it which meant the deprivation was only lawful if the condition was being complied with. The registered manager and staff were unaware of this condition and we found it was not being complied with which meant the person was unlawfully being deprived of their liberty.
● Staff knew about safeguarding procedures and told us how they would recognise and report any concerns. However, the registered manager and provider did not operate a system to ensure any safeguarding referrals were recorded, investigated and learned from.

The above evidence demonstrated that people were being deprived of their liberty without lawful authority and suitable safeguarding systems had not been implemented and operated effectively to prevent abuse.

This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- There were enough staff to meet people's needs. One person said, "There are enough staff to look after me. The staff are lovely."
- A staff member said, "We have enough staff, I think. We get to [people] as quick as we can if they use the call bell. None of them have ever complained to me."
- Staff recruitment checks including criminal checks with the Disclosure and Barring Service were carried out to ensure people were protected from being supported by unsuitable staff.

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; 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

At our last our last inspection, the registered person had not established an effective system to enable them to ensure compliance with their legal obligations and the regulations. The registered person had not established an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. This was a breach of Regulation 17 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 continued to be a lack of effective oversight from the registered manager and provider. Very few audits were completed and those that were completed were ineffective. For example, the monthly medicines audit had not identified the issues that we found during our inspection and had therefore not effected any change or improvements.
● The infection prevention and control audit had also not identified the issues we found and had not been effective in ensuring safe practices were implemented and followed. This left people at risk of harm from continued unsafe practice.
● The provider continued to fail to implement a system that ensured complete, contemporaneous records in respect of each person's care were maintained. We found that not all care plans had been reviewed and updated which continued to leave people at risk of incorrect or inconsistent care.
● There was no effective system in place to manage and assess people's risks or improve the quality of care delivered to people. For example, some people required bowel or food and fluid monitoring due to associated risks to their health and wellbeing. There were no checks of these charts so there was no system for identifying concerns or escalating to relevant professionals. This left people at risk of their health deteriorating.
● Since the last inspection, a 'touch point' cleaning log had been implemented which stated that frequently touched surfaces should be cleaned hourly to prevent the spread of infection. However, these logs showed that touch points were only being cleaned once per day on most days. There were no checks of these logs so this issue had not been identified and no action had been taken which left people at increased risk of cross-

infection.
● The provider had failed to act on known environmental risks including the required upgrade of the fire alarm system. The provider had been aware of the risks and need for improvement but had failed to implement change until prompted during the inspection.

The above evidence demonstrated that people were placed at continued risk of harm through the lack of effective governance systems. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Providers must ensure that their rating is displayed conspicuously and legibly at any location where a regulated activity is delivered.
● At the previous inspection, the provider was not displaying their most recent rating in the home.
● At this inspection we found that again, the provider was not displaying their most recent rating. They had an old inspection report displayed in the foyer which displayed the incorrect current rating.
● We asked the provider and registered manager to ensure their most recent rating was displayed but they continued to display an out of date rating.

The above evidence demonstrated that the provider had failed to display their current rating, This was a breach of regulation 20A (Requirement as to display of performance assessments) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider is required to notify CQC of certain events that occur at the service such as allegations of abuse, serious injuries and deprivations of liberty. This is required by law.
● We found there were 12 allegations of abuse that occurred between October 2020 and the date of this inspection. The service was aware of these and had not notified CQC.
● One person had an authorisation to deprive them of their liberty and CQC had not been notified, as required by law.

The above evidence demonstrated that the provider had failed to notify CQC of allegations of abuse and deprivation of liberty authorisations. This was a breach of regulation 18 (notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009

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
● People did not always receive person-centred care that led to good outcomes for them. This was because care plans did not contain individualised information and people had not always been involved in their care planning.
● One person was receiving end of life care, yet their 'Final Days' care plan was blank so it was unclear what their wishes were and how staff could provide personalised care when there was no care plan to work from. Some very basic information was recorded but this was not sufficient for staff to provide person-centred care.
● Care plans lacked detail about individual preference and the specific way that people liked to be supported. For example, one person's washing and dressing care plan did not consider whether they preferred male or female staff and contained no detail about how the person liked to be supported. This meant staff did not have access to the information they needed to provide person -centred care.

The above evidence demonstrated that the provider had failed to provide person-centred care that was

appropriate to meet people's needs and reflected their preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

- The service had been supported by the local authority and external professionals for a significant period of time. They were being supported to improve standards using an action plan, however, significant progress had not been made and there were a high number of outstanding actions to be completed.

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 11 HSCA RA Regulations 2014 Need for consent Consent was not gained from people for restrictions such as bed rails and locked doors. People's mental capacity had not been assessed when required, for example, covert medicines were being administered without an assessment of the person's mental capacity.

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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify us of events including allegations of abuse and previations of liberty, that are required to notify us of, by law.

The enforcement action we took:

We took enforcement action to cancel the manager's registration.
We took enforcement action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The service failed to ensure person-centred care was delivered as people did not have personalised care plans in place to ensure staff knew how to meet thier needs.

The enforcement action we took:

We took enforcement action to cancel the manager's registration.
We took enforcement action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not recieve safe care as the provider failed to assess and mitigate risks to people including risks to people's health and welfare and risks assocaited with the physical envionments. Medicines were not safely managed. Infection preventional and control practices were not safe.

The enforcement action we took:

We took enforcement action to cancel the manager's registration.
We took enforcement action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 13 HSCA RA Regulations 2014

personal care	Safeguarding service users from abuse and improper treatment Some people were unlawfully deprived of their liberty.

The enforcement action we took:

We took enforcement action to cancel the manager's registration.
We took enforcement action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate an effective governance system to assess, monitor and imporve the quality and safety of care provided to people.

The enforcement action we took:

We took enforcement action to cancel the manager's registration.
We took enforcement action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider failed to display their current rating at the location address.

The enforcement action we took:

We took enforcement action to cancel the manager's registration.
We took enforcement action to cancel the provider's registration.