Ranc Care Homes Limited

Manton Heights Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Manton Heights Care Centre (Manton Heights) is a residential care home providing accommodation and personal care for up to 91 people aged 65 and over at the time of the inspection. The service is split into two buildings on one site. One building supports people with an acquired brain injury and the main building supports people living with dementia. The main building consists of three units, two units are on the ground floor separated by a locked door and a third unit is on the first floor. At the time of our inspection, the main building was supporting 60 people. There is a shared dining room and lounge on each unit and a shared garden area.

People's experience of using this service and what we found
The management did not ensure staff were sufficiently trained and supported to understand and fulfil the requirements of their roles and provide safe care. Most staff were not aware of what abuse looked like and how to report it. They were unclear about their duty of care responsibilities to seek appropriate medical support for people who needed it.

Staff told us they often worked below the required staffing levels in practice due to staff shortages and how tasks were deployed. This meant they did not have time to spend quality time with people and ensure people remained safe. As a result there have been a significant number of falls and safeguarding incidents at the service. One serious case is currently being investigated by the safeguarding team.

This also impacted on safe administration of medicines. Medicine rounds times took so long there was a risk that people who received medicine again at the next round could be overdosed due to insufficient time gaps between doses.

People and relatives gave mixed views about the care at Manton Heights. Some people told us they felt safe and although they said there was not enough staff, they were happy living at the service and that staff treated them well. People told us they would like staff to be able to sit and spend time with them. They felt the home was kept clean and the food was good. Some relatives agreed with this view.

However, other people told us the home had deteriorated over the last nine months with many staff leaving resulting in a shortage of staff and often having to wait longer periods when calling for assistance.

People told us staff did not have time to talk to them and they found that management was unhelpful and at times unprofessional in their attitude. Other relatives were very unhappy at the level of poor care and failure to seek appropriate medical support. They also felt there was a lack of responsiveness when raising complaints and poor communication generally.

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 provider had systems in place to monitor care and incidents at the service and to investigate concerns raised. However, these have proven to be ineffective in identifying the concerns we found during the inspection process and when external complaints had been received.

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

Rating at last inspection:
The last rating for this service was requires improvement (published 03 June 2020). The provider completed an action plan after the last inspection to show what they would do and by when to improve.

Why we inspected
The inspection was prompted in part due to concerns received about the management of people's care needs and falls in the service. There had also been a specific incident of harm currently being investigated by the local councils safeguarding team, low staffing levels and the managers attitude and style of management was also a concern. A decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous focused and comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe 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.

Following discussions with the provider about these concerns they have recognised improvements to their systems and management of the service needed to improve. They have started to implement plans for change but these were not yet fully in place at the time of the inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Manton Heights Care Centre 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 breaches in relation to the safe management and reporting of falls, failure to ensure staff are sufficiently trained and supported to fulfil their roles and safe and effective monitoring of the service at this 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?

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.

Manton Heights Care Centre

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 as part of our Thematic Review of infection control and prevention in care homes.

Inspection team
This inspection was carried out by three inspectors. One inspector focused purely on the completion of the Thematic Review of infection control and prevention in care homes.

Service and service type
Manton Heights Care Centre 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 in post but they were not yet registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 30 minutes notice of this inspection in order to review and agree the organisations procedures in relation to infection prevention and control due to the Covid-19 pandemic.

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, Healthwatch and professionals who work with the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and

social care services in England. We used the information the provider sent us in the provider information return (PIR) as well as reviewing other information we asked the provider to send us. This PIR 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 five people who used the service and three relatives about their experience of the care provided. We spoke with 11 members of staff including the provider, a senior manager, the manager, senior care workers, care workers and housekeeping staff.

We reviewed a range of records. This included four people's care records and two people's medication records. We looked at three staff files in relation to recruitment, induction and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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 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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

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

At our last inspection we recommended the provider followed current good practice in relation to monitoring incidents and uses this information to effectively inform the staffing levels required to meet people's needs safely. The provider had not made improvements.

- Risk assessments were ineffective in guiding staff to understand how to safely support people who were at a risk from falls. Staff did not always record observations of people's behaviour and responses and care records were often difficult to read due to the standard of handwriting. This meant people's pain and the impact of falls or other incidents was not always recorded and therefore could not be identified, analysed or acted upon.
- There was a lack of consistency of staff knowledge about what to do when a person falls and who they should report this to. Some staff did not understand their duty of care to seek medical attention following an injury and those who did told us they were not empowered by the manager to do so. The manager was also unclear about why medical attention was not appropriately sought. This resulted in a serious incident which is currently being investigated.
- The staffing levels were insufficient to safely monitor the care of people and risks associated with their needs. Staff were seen to be very busy and constantly moving from one person to the next to support people who were in their bedrooms. However, this often left long periods where upwards of 11 people were left unsupported in communal areas such as the lounge. We observed one person who was very unsteady sitting on a table instead of a chair. A member of the housekeeping staff eventually supported them to sit safely as the care staff were busy elsewhere.
- Staff had very little understanding of the various forms of abuse and what this looked like in practice. Some staff had no knowledge of this at all. Some staff were unaware they could whistle blow and how they could do this. Most staff were unaware they could report concerns to external professionals or even to their own senior management. This meant there was a continued risk of people experiencing harm or abuse that would go unnoticed and unreported.
- Staff were not supported to be sufficiently trained to be able to safely fulfil the requirements of their roles. Staff told us they did not receive any checks on their competence in practice and no follow up after e-learning to check their knowledge.
- Staff told us the manager had never given them the opportunity to reflect on things that had gone wrong to promote learning and to drive improvement. The staff team felt very unsupported by the management team to empower them to develop.

Due to staff poor understanding of abuse awareness and the responsibilities of their roles, people were placed at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) and regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Due to the managements failure to act and seek appropriate medical care and report a safeguarding incident, one person was harmed. 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.

The provider responded during and after the inspection. They recognised practices and processes to ensure people were safe needed to be improved. They explained plans to implement new systems and changes in the management structure.

Using medicines safely
● We found overall medicines to be safely managed. However, one area of concern was highlighted in relation to the risk of overdosing people. There was no effective and consistent practice or system for recording the times of medicines people had as and when required.
● Medicine rounds also took a long time as only one senior staff was responsible for this. The impact to people meant there was a risk medicines would be given again without knowing if there had been a sufficient gap between doses.
● We spoke with the manager and the provider about this and while they were taking action in the future in the form of a GP review of all medicines. This had not taken place and did not address the identified concern.

Preventing and controlling infection
● We observed there were insufficient staff to safely monitor the needs of one person self-isolating in their room due to risks of the Covid-19 pandemic. This person was observed to leave their room and mix with other people in communal areas on at least five occasions in a three-hour period. The risks to others in this situation of cross contamination of infection were greatly increased and gave cause for concern about how staff would be able to safely manage with their current staffing levels if there was an outbreak of Covid-19.
●Staff had a good awareness of their responsibilities when it came to Covid-19 and infection prevention and control. Staff wore the appropriate PPE which was changed between supporting different people. PPE was seen to be correctly disposed.
● Housekeeping staff ensured all areas were constantly cleaned using the correct cleaning products. Staff understood what had been shared with them in relation to Covid-19 but were unsure of where to go to look up further information and guidance.
●The manager told us that there were no specific risk assessments to look at additional risks and measures to mitigate those risks for people and staff who fell into the high-risk categories for Covid-19. These included people and staff who were a part of Black and Minority Ethnicity (BAME) or due to underlying health conditions. However, the manager did later confirm there were plans to do this in the near future.

Staffing and recruitment
● The manager and senior managers told us there were sufficient staff on duty and any deficit would be supported by regular agency staff and the rota supplied supported this. However, in practice this was not seen to be the case, one unit was a staff member short and one senior staff member was busy most of the morning administering medicines. This left only three care staff instead of the required five to support people with their care needs.
● The impact to people of this was that we observed people having to wait extended periods of time for assistance to move from their bed to their chair as this required two staff to support them and only one staff

was available at that time.

● The provider had ensured staff had the correct pre-employment checks before they started work. However, we did discuss with the provider the need to ensure more robust checks on verifying references and staff employment history to ensure the most suitable people for each role was employed.

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The service had a manager in post who had applied to the CQC to become registered. However, at the time of the inspection, this application this was still going through CQC internal processes and had not yet been approved meaning there was no manager in post registered with the CQC.
- Prior to and during the inspection we had asked the manager and the provider to send us various records in relation to falls, people's care and support, staff training and development and recruitment and quality assurance and monitoring processes. We found a lot of deficits in the quality and content of these records.
- Audits completed by the manager and shared with the provider showed little insight into the reason for falls and no meaningful analysis of patterns and trends and insufficient actions for follow up with no outcomes recorded.
- The provider was unable to locate an incident report for a serious incident. The manager had failed to notify us of this incident until after five weeks and only then once other external professionals had done so. This fact had also not been identified by the provider using their own quality monitoring systems.
- The manager had not conducted any supervisions or follow up assessments of staff competence in practice. Staff were not supported to learn from incidents and there was no clear vision or values that staff were aware of to drive improvement in quality and safety of care. This lack of staff support and development had also not been identified by the provider in the nine months of the manager's employment nor during senior managers investigation of concerns raised.
- The staff failed to understand the full requirements of their roles beyond providing basic care needs. The manager did not understand how to professionally and effectively support staff with performance development. Staff were insufficiently trained and unsupported and told us they felt bullied by the manager and did not feel they could go to the provider. Staff told us they had attempted to complain to human resources and other senior staff and not been listened to and their complaint not responded to.
- One relative told us how they too had emailed the manager and the provider to complain about poor care and treatment of their family member and they too had not received a response. Another relative told us how they had complained once to the manager and would not bother to do so again as they were rude, offensive and inappropriate. They too had complained to senior management and told us they were ignored.
- A senior manager and the provider did share with us new systems they plan to implement but these were not yet fully implemented or embedded and so had not yet impacted on the service and on quality and

safety of care.

Due to poor governance and provider oversight of staff knowledge and practice, people were placed at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They recognised systems and processes to ensure effective provider oversight needed to be improved. They explained plans to implement new systems and changes in management structure. These plans had started to be introduced but were not yet fully implemented or embedded.

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 has been in discussion with inspectors prior to, during and following the inspection. They recognised they need to do better to improve systems and ensure they have a good oversight of the issues at the service and how these are being managed. This includes processes for investigating concerns by senior management which were not fully open.

● However, there is clearly a lot of work to be done to ensure that the service staff teams are supported and empowered to fully understand their roles in order for them to know what they should be doing and how to do it. We have found that records do not record incidents or the impact of these incidents and currently staff told us they are scared to speak up. This has led to a closed culture and the risk of further incidents not being reported and people no receiving the care and treatment they require.

Working in partnership with others

● The manager has on occasion been obstructive when it comes to sharing requested records and working with external professionals such as district nurses and adult safeguarding teams. This has led to difficulty in assessing the risks and treatment needs of people placing them at risk of harm.

● One health and social care professional told us, "There have been a number of safeguarding concerns raised from other parties regarding significant service user falls within the home, dignity in care of individuals, personal care needs not being met in a timely manner and lack of basic care. We have received feedback from professionals and family members regarding the manager's unhelpfulness. Whistleblowing concerns regarding the manager's leadership style and lack of responsiveness to a DoLS application."

● This shows there needs to be an improvement in how the manager and provider works with external professionals to work openly and collaboratively to promote good care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with neglect, falls and other forms of unsafe practice because of a lack of staff skills and knowledge.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not safe from harm and abuse. The provider had failed to ensure appropriate medical attention was sought for five weeks for one person following two falls. This has led to prolonged suffering and obvious expressions of pain and likely permanent changes in mobility. This incident was not report to safeguarding teams or the CQC until after external professionals had done so.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who use services and others were not protected against the risks associated with neglect, falls and other forms of unsafe practice because of a lack of staff training and knowledge. Processes and systems to assess monitor and improve the quality and safety of care were not effective in mitigating risks and identifying concerns. Systems in place did not promote effective provider oversight and a

culture of staff not being empowered to report or take appropriate action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff were suitability trained and supported to enable them to fulfil their role and fully understand their responsibilities in relation to safeguarding, whistleblowing processes, abuse awareness and dementia awareness. This has meant there is a continuing risk that harm and abuse will continue to go unnoticed and unreported.