RCH Care Homes Limited

Manton Heights Care Centre

Inspection report

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01 September 2020
07 September 2020
08 September 2020

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Manton Heights Care Centre is a residential care home providing accommodation and personal care for up to 91 people aged 65 and over.

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 unit manager of the brain injury unit told us they were supporting 12 people. The manager of Manton Heights Care Centre told us there were also supporting 74 people in the main building. 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

We inspected the service to review outcomes of the actions the provider had told us they would implement after we identified numerous concerns to safe care and treatment of people at the previous inspection on 30 July 2020.

People were still a risk of unsafe care and treatment as systems had not yet been fully implemented to effectively monitor staff practices and understanding of the requirements of their roles.

Some people continued to experience alleged abuse and incidents resulting in injuries which were not always reported and acted upon appropriately by the provider and senior managers.

People were supported in the main by staff who were not yet sufficiently trained in areas of identifying abuse and who did not have the understanding of how to report it. Staff had not yet received the required training and supervision to develop their practice.

People's medicines were still not always administered and recorded safely meaning they were at risk of over dosing or missing medicines.

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.

Staffing levels for care staff had improved which meant people were less likely to wait for care or to be alone in their bedrooms and communal areas for long periods of time.

People and relatives gave mixed reviews of their experience but were mostly positive and agreed that the

service culture and atmosphere had improved since the change of management. One person told us, "[Staff] attitude is always helpful and empathetic. I have only had to complain once about a staff member, it was their approach but we have now ironed out this misunderstanding." Another person said they sometimes had to wait up to 10 minutes for support with using the toilet.

Relatives told us they had concerns previously about staffing levels and people not always receiving personal care. Relatives also said senior managers were not always responsive to complaints. However, they felt these had now been addressed since the new manager had been in post.

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 08 September 2020). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations and the service remains in special measures.

Why we inspected
We undertook this targeted inspection to check whether the actions the provider had stated would be taken following the previous inspection on 30 July 2020 had been implemented. The overall rating for the service has not changed following this targeted inspection and remains inadequate.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

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 continued breaches in relation to reporting and acting on safeguarding concerns, medicines administration, staff training and development and poor provider and managerial oversight of the service at this inspection.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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?

Inspected but not rated

At our last inspection we rated this key question Inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service effective?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question Inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Manton Heights Care Centre

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check whether the provider had met the actions of their improvement plan submitted to the CQC on 10 August 2020. This was in response to concerns identified at a previous inspection on 30 July 2020 in relation to the safe care and treatment of people, insufficient staffing levels, medicines management, staff training and awareness of the requirements of their roles and poor governance.

Inspection team
This inspection was carried out by four inspectors. Two inspectors carried out the site visit and a further two inspectors assisted with other aspects of the inspection process such as contacting people, relatives and other professionals.

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 newly appointed a manager but they did not have a manager registered with the Care Quality Commission. This means 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 a short period of 30 minutes notice of the inspection as we wanted to confirm the procedures for minimising the risk of infection of Covid-19 and allow the manager time to prepare for visitors in relation to working safely.

What we did before the 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.

We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the providers action plan submitted on 10 August 2020, as well as reviewing other information we asked the provider to send us. We used all of this information to plan our inspection.

During the inspection-
We spoke with four people who used the service and seven relatives about their experience of the care provided. We spoke with 18 members of staff including a senior manager, the manager, the deputy manager, senior care workers, care workers, therapists, activity co-ordinators and housekeeping staff. We reviewed a range of records including care records and two people's medication records. We looked at a variety of records relating to the management of the service, including policies and procedures. We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

After the inspection
We continued to seek clarification from other health and social care professionals and reviewed validated evidence found. We spoke with two professionals who regularly visit the service.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of specific concerns we had about infection prevention and control, medicines, staffing levels, systems for safeguarding people from the risk of abuse, staff awareness of safeguarding and how lessons learned were shared with staff for their learning. We will assess all of the key question at the next comprehensive inspection of the service.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management; Staffing and recruitment

At our last inspection, the provider failed to robustly assess risks relating to the health and safety and welfare of people. Risk assessments were ineffective in guiding staff to understand how to safely support people who were at risk of falls. Concerns were not always recorded and reported. Staffing levels were insufficient to safely monitor the care of people. Staff did not have a knowledge of whistleblowing and safeguarding people in their care. This was a breach of regulations 12 (Safe Care and Treatment) and 13 (Safeguarding Service Users from Abuse and Improper 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 regulations 12 and 13

- During this inspection, we found that nine out of the 18 staff we spoke with still did not have an understanding of safeguarding people and how to whistle blow about concerns.
- We were made aware by sources outside of Manton Heights Care Centre of a serious allegation of sexual assault which had not been reported to the CQC or other relevant authorities. People involved in the allegation were not safeguarded during a process of internal investigation. These actions compromised what might have been a criminal investigation.
- There was an additional serious safeguarding incident that was reported to the CQC by the provider which showed the involvement of two staff members with a further six staff members implicated, who had also failed to prevent and report alleged abuse.
- We continue to be concerned about a culture of abuse and neglect where staff continue to fail to safeguard people and fail to report acts of abuse. The provider, who was also aware of one of these allegations, failed to act appropriately and with honest transparency.

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 practices and further training and development and 1:1 support for staff to better understand their role in safeguarding people.

● The provider had increased the levels of care staff to sufficient levels to enable staff to safely monitor the risks associated with people's needs.
● Some staff had been given support and training in the areas of safeguarding and as a result were able to demonstrate a good level of understanding about what abuse looked like and how to report it.
● Staff told us they felt more confident now to report abuse following changes in the management structure at the service. However, we found this was yet to be evidenced in practice.
● The provider had reported the most recent incident of abuse in a timely manner and acted appropriately to safeguard those involved.

Using medicines safely

At our last inspection we found there to be concerns about safe administration 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 regulations 12

● At this inspection, there continued to be concerns in relation to medicines administration and management. We observed one agency staff member not sign the medication administration record (MAR) for one person until over two hours after the medicine was administered. When we asked the staff about this they admitted they had forgotten to sign the MAR chart that morning. Not signing MAR immediately after administration of a medicine posed a significant risk of experiencing a medicines error and likely over dose, as there was the risk that the staff member would not be able to recall what medicines were given, the time and the dose.
● There was still no clear guidance in place for staff to record the times for medicines that were to be given more than once in a day to ensure a sufficient gap. This meant there was still a risk of people being given too much or too little medicine to safely manage their needs. We had discussed this with the manager and the provider at the previous inspection and were told the issue would be addressed, however, it was clear this had not happened. We discussed it again with the manager, but it was clear the risk was not fully understood.
● We observed one staff member administer pain medicine to one person who was not ready to take the medicine. This medicine was left in a pot for the person under the care of another staff member who had not been involved in the medicine being administered and checked. The person's care plan stated they needed staff support to administer medicines. This demonstrated a fundamental lack of understanding by the staff of the risks and responsibilities around safe medicines management and was a direct contravention of the providers medicines policy.
● We have continued to receive notifications of a further three medicines errors following this inspection. This showed a continual risk of unsafe medicines practice and that staff awareness and competence in this area was not sufficient to ensure people were safe.

The provider responded during and after the inspection. They spoke with the staff concerned and have started an investigation into one of the concerns we identified. They have also agreed to again refresh the training and assess the competence of all staff who are responsible for medicines.

Preventing and controlling infection

At our last inspection we found risks in relation to the safe management of the risk of infection prevention

and control resulting the potential risk of spreading of Covid-19. There were also no updated risk assessments to consider the specific and additional risks for people who come under the black and minority ethnic groups (BAME). 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 regulations 12

● During this inspection we observed concerns in relation to the safe prevention and control of infection. We observed one staff member walking from a person's bedroom with an open, soiled incontinence pad in their hand. They told us this was because they were no longer allowed to have the correct yellow bags and bins for hazardous waste in people's bedrooms. They told us they were using domestic bin liner bags and had forgotten to take one to the person's' bedroom.
● We also observed how one person was self-isolating for 14 days as per government recommendations following admission from hospital. However, the stations used by staff to remove dirty PPE and put on clean PPE were not near or inside the bedroom. This meant staff risked the spread of infection for a person who was potentially Covid-19 positive as staff had to walk to the nearest donning station in order to change their Personal Protective Equipment (PPE) and sanitise.
● Staff did tell us they had recently received refresher training on Covid-19 related PPE and Infection prevention and control measures.
● Staff also told us, and we saw from the rota, there were insufficient numbers of housekeeping staff. The manager told used agency staff to enable one housekeeper on each unit as well as one person monitoring the laundry. This meant housekeeping staff had to work across units including one unit where the manager had told us they were supporting one person who had tested positive for Covid-19. One staff member told us the insufficient staffing numbers also made it difficult to ensure high traffic areas such as banisters and switches were cleaned enough times each shift to minimise the risk of spreading infection.

The provider responded during and after the inspection. They recognised practices and processes to ensure people were safe needed to be improved and have now ensured yellow bags of hazardous waste are available in each room and each room has its own station for the safe disposal and changing of PPE. They also continue to recruit for permanent housekeeping staff. A senior manager also told us they had plans to conduct risk assessments for all people and staff who had underlying health conditions or who fell into the BAME category.

Learning lessons when things go wrong

At our last inspection, staff were unaware of using lessons learnt to improve practice. The provider told us in an action plan submitted on 10 August 2020 that they would be holding staff meetings between 10 and 31 August 2020 to support all staff to understand about how to use lessons learnt to improve practices and culture.

● At this inspection, only three of the staff we spoke with were able to tell us they have been supported to understand and learn from incidents. It was also clear from continued safeguarding incidents and a failure to report these that there continues to be a culture of not learning from past mistakes.

Inspected but not rated

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.

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of specific concerns we had about staff training and development. We will assess all of the key question at the next comprehensive inspection of the service.

Staff support: induction, training, skills and experience

At our last inspection, 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. This was a breach of regulation 18 (Staffing) 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 regulations 18

● We had identified at the previous inspection e-learning alone had not been effective and the provider had not checked staff understanding. At this inspection, we found that 12 out of 18 of the staff we spoke with told us they had not received any training yet other than the e-learning they had already completed and continued to use as a fresher course. Six staff members told us they had received one training course during the period of the providers action plan but they were unable to recall the topic or content of the training. This meant there were no learning outcomes applied to staff practices making the training and follow up of competency ineffective.
● 14 of the staff we spoke with told us they had not yet received 1:1 supervision or any on the job coaching which the provider had stated in their action plan they would give to all staff throughout August 2020. A record of supervisions sent to us by the manager showed only eight out of 54 staff had received supervision in August 2020.
● This meant without development and support for staff there was a continued risk of incidents not being managed and people not being safeguarded due to a lack of understanding of what abuse looks like in practice and their role in reporting and recording concerns.

The provider responded during and after the inspection. They recognised practices and processes to ensure staff had the right training and support to be able to fulfil the requirements of their roles needed further work. They submitted further plans to ensure the training took place and all staff had supervision and assessments of competency.

● Housekeeping staff confirmed they had received refresher training on infection prevention and control in the month of August 2020.
● The new manager and deputy manager had both received in-depth inductions which were still in process and they continued to be supported to understand systems and processes by senior managers from various departments. They both gave very positive feedback about the training and support they had received.
● Four staff members told us they had received training and supervision and felt that it was supportive.

Inspected but not rated

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. The purpose of this inspection was to check if the provider had met the requirements of specific concerns we had about the management and staffs understanding of the requirements of their roles, poor provider and
At the last inspection this key question was rated as inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

managerial oversight and a failure to learn from concerns to improve the care. We will assess all of the key question at the next comprehensive inspection of the service.

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

At our last inspection, we had significant concerns about the practices of the manager, the culture of the service and the manager and provider oversight required to ensure safe care and treatment. We also had concerns over the systems and records in place to monitor quality of care, transparency of incidents and the provider and manager support of the staff team. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulations 17

● The provider had failed to ensure that the new manager was aware of their responsibilities to also manage the safe care and treatment of the acquired brain injury (ABI) unit which was a part of the Manton Heights Care Centre. Therefore, until inspectors raised this, the manager had no knowledge of the people, staff, care or concerns at the ABI unit side of Manton Heights Care Centre. This meant there was no managerial oversight on a daily basis at this part of Manton Heights Care Centre and the manager was not aware of .a serious safeguarding allegation that had gone unreported.
●Since the last inspection, the manager who was employed at that time no longer works at Manton Heights Care Centre. A new manager has been employed. However, we have not received an application to register a manager which has been approved.
● During this inspection, we found that the provider had not met the deadlines they had set for themselves in their submitted action plan to support the improvement of staff practice, awareness, skill and culture. Staff supervisions had only occurred for eight out of 54 members of the staff team. Care staff had not received the promised coaching and training required to fulfil their roles. As a result, there continued to be incidents of alleged abuse, poor practice and medicine errors.
● We were told at the inspection in July 2020 that there was to be a new governance system implemented which would enable managers and the provider to better monitor the quality of care provided. This new system would also enable better analyse of falls and other incidents to look for trends which could aid

improvement. The manager told us at this inspection that they were not yet fully inducted into this new system and therefore they had not yet fully implemented it.

● There had not been learning that aids the improvement of care. Only four of the staff spoken with told us they had discussions with senior staff or manager about how to improve practices. We found that areas of concern identified in previous inspections in relation to staff competencies, medicines, safeguarding and transparency of reporting had not been addressed. There remain concerns about the quality of documentation and staff not always fully recording relevant information in daily care records.

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

● We found at this inspection there continued to be a culture of not reporting serious incidents and safeguarding events to the appropriate authorities and the CQC. Three serious incidents since the last inspection had not been reported to the CQC in an open and timely manner as per the requirements of the regulations.

● One serious safeguarding incident had not been reported to the CQC at all and other serious incidents were not reported for almost three weeks. In one case the provider only submitted a notification following CQC inspectors having to prompt the provider and senior managers. This placed people at risk of alleged abuse not being acted on appropriately and people at risk of further unsafe care. This failure to report and appropriately act to manage risks of abuse shows a fundamental flaw in the governance systems.

● The provider also failed to notify the commission of a change of the legal entity of their business which is a requirement of their registration as a provider. Not only did they fail to notify the CQC of this change, but they have continued to manage their business and submit applications to add locations and managers at Manton Heights Care Centre using a false business name.

The providers failure to ensure that reportable incidents are appropriately reported and shared with the relevant authorities. This was a breach of regulation 20 (duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The providers failure to ensure serious safeguarding incidents were reported to the CQC was a breach of Care Quality Commission (Registration) Regulations 2009 Regulation 18 – Notice of other incidents and 15 – notice of changes.

The provider responded during and after the inspection. They recognised systems and processes to ensure effective provider oversight needed to be improved and submitted a further action plan. They have also since told us they intend to submit a notification for the change of their legal entity and address failure to report other incidents with the staff team and managers through internal investigations.