MMCG (2) Limited

River View Care Centre

Inspection report

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17 October 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was completed on 24, 25 September and 2 October 2018. A follow up visit took place on 17 October 2018. This was a comprehensive first inspection for the new provider. Any newly registered service required inspecting within 12 months from registration to ensure they are compliant with regulations.

The service was taken over by MMCG (2) Limited in August 2017, prior to which the care was provided by another service provider. Some of the previous staff transferred as part of the acquisition, however, some previous members of senior management within the service left.

River View Care Centre is a 137 bed service that provides facilities over three floors to older adults with varying needs, including living with dementia. The service is broken down into seven units, that are distributed as: two on the ground floor, three on the first floor and two on the second floor. River View Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. MMCG (2) Limited are responsible for the operation of the service, with Lifestyle Care Management Limited holding responsibility for the property. During the first two days 115 people used the service. By the third day the numbers had reduced to 113. Two people on end of life care passed away during the inspection process.

A registered manager had been in post since the service was taken over by MMCG (2) Limited. The manager was previously registered with the CQC in April 2017, under the old provider, with a new application since made by the new provider. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was rated Inadequate.

People were not kept safe. Risk assessments and comprehensive documentation was not in place to ensure people were offered responsive safe care and treatment. Care plans contained minimal information, with crucial information missing. The lack of information meant people were put at risk of harm.

Medicines were not always managed safely. Whilst we found that medicines were generally stored safely and appropriately administered, guidelines were not in place for two people who were given medicines covertly. Nurses spoken to were unclear of the correct protocol that was to be followed prior to covert medicines being administered.

People were not being kept safe due to a failure in appropriate monitoring and recording of the environmental risks and risks to people. A leak in the roof gave cause for serious concern around safety to people and staff. The service did not have robust recruitment processes in place, to ensure staff employed

were safe to work with people.

Staff did not appropriately record information. Incidents were not always reported or understood to be reportable, therefore information was not accurately updated in daily records. Nutrition and hydration records were maintained for all people; however information was not cross referenced or analysed as required. As a result some referrals were not made to health professionals to seek further clarity on change in people's hydration and nutrition.

Neither the provider nor the registered manager had effective systems in place to audit care documentation. Such systems would monitor the care provided in relation to the care plans, therefore highlighting any errors as and when these were occurring. This was specifically important given the number of discrepancies noted between day and night records.

People's care was not always delivered in a dignified way. Their independence was not promoted nor their privacy protected. On occasions it was found that staff did not maintain confidentiality, by speaking about people in front of others. Care was found not to be responsive to their needs, and often not effective. People were not always consulted about how they wished to have care delivered, or were not consulted prior to being assisted. This meant that whilst staff had received training in the Mental Capacity Act, they did not practice the fundamental standards of the legislation.

The registered manager completed ad hoc audits. This meant that they did not have a comprehensive overview of the service. Whilst a management structure existed, this was not effective in ensuring governance of the provision. Information was not always analysed or passed to the correct people, leading to errors in care delivery and poor management. The service, although specialising in delivering care to people living with dementia, did not environmentally meet the needs of the people.

The service was operating at 100% in all company mandatory training. Staff were receiving supervision as per the provider's policy guidelines. Team meetings took place frequently.
People were safeguarded from abuse. Staff had received training and understood what measures needed to be implemented to appropriately investigate and monitor safeguarding issues.

During the inspection we identified several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by the CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Services placed in special measures will be inspected again within six months.
- The service will be kept under review and if needed could be escalated to urgent enforcement action

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.

Risks to people were not appropriately assessed nor were measures implemented to keep people safe.

The environment presented a significant immediate risk to people's safety. No measures to assess the risk were put in place.

Medicines were not always managed safely. Guidelines for covert medicines were not in place.

The service did not have robust recruitment processes in place, to ensure staff employed were safe to work with people.

People were safeguarded from abuse. Measures had been implemented to appropriately investigate and monitor reported safeguarding issues.

Is the service effective?

Requires Improvement

The service was not always effective.

Appropriate measures had not been implemented to ensure people's nutritional and hydration needs were met, due to poor recording and documentation.

The service failed to cross reference records and make referrals as required.

The service although catered for people with dementia, did not fully meet their needs. The environment was not appropriately designed to meet people's needs.

Staff received supervisions and attended team meetings.

Consent was not always sought from people. Although staff had received training in the Mental Capacity Act.

Is the service caring?

Requires Improvement

The service was not always caring.

Privacy and dignity was not protected, with doors being left open when assisting with personal care, and where issues around self-preservation of dignity were known for people.

There was insufficient evidence to illustrate people were involved in their care development.

Whilst the service generally ensured people's confidentiality was maintained when speaking about people to one another. Daily records were filed near each room entrance, therefore accessible to any visitors.

Is the service responsive?

Inadequate

The service was not always responsive.

People's care plans were not reflective of their changing needs.

People did not have all their personal care needs met.

Appropriate alternative measures had not been put into place to manage and respond to people's needs as and when these arose.

Complaints were appropriately managed and recorded.

Is the service well-led?

Inadequate

The service was not well led.

Effective processes were not in place to monitor the accuracy of the care provided.

Audits had not been completed consistently to identify where improvements were needed in relation to service documentation.

Leadership of the service was ineffective.

The principles of duty of candour had not been followed.

River View Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 24, 25 September and 2 October 2018 and was an unannounced inspection. The inspection team consisted of the lead inspector on all three days, with a bank inspector on the first two days, and an inspection manager on the third day. A specialist advisor, dementia nurse was in attendance on all three days of the inspection. We completed a further visit on 17 October 2018, as a follow up to the inspection. This visit was used to gather further information to inform the inspection findings.

We received a PIR from the service and used this to help inform the inspection process. The PIR is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We requested local authority reports and details of any significant issues from the local authority. These may include concerns that fall short of the safeguarding criteria, but are of significance because if left un-addressed can lead to safeguarding issues. We received two complaints about the provider and were contacted by one whistle-blower, during the inspection process.

During the inspection we spoke with 18 members of staff. This included the registered manager, two clinical managers, five registered nurses, five care staff, two domestic staff, the administrator, one maintenance person and the head chef. We spoke with five people who use the service and five relatives of people who were authorised to speak with us on their behalf. In addition, we spoke with two care professionals from the local authority and a visiting healthcare professional. We employed the Short Observational Framework Inspection (SOFI) over lunchtime during day two of the inspection. The SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We made further general observations throughout all three days of the inspection, including during medicine rounds.

Records related to people's support packages were seen for 14 people. In addition, we looked at a sample of records relating to the management of the service. We viewed records related to staff recruitment for 12 staff.

Inadequate

Is the service safe?

Our findings

The CQC received intelligence during the inspection, including staff and family members raising concerns for people's safety residing at the service. The issues raised included people being put at risk, due to poor documentation and recording systems. Concerns were also raised around medication management as well as staff approach towards people not always being dignified and caring.

During our first day of inspection a tour of the service was completed. This highlighted a number of significant safety issues, many of which put people at immediate risk of harm. We found call bells in communal bathrooms were tied up out of people's reach. This meant people and assisting staff were unable to call for assistance should the need arise. Some people within their rooms did not have call bells within easy reach. One person's call bell had fallen under the bed, with the bed positioned over the call bell. On day two of the inspection all call bells were found to be untied and within reach of people. However, on day three we found three call bells had been tied up again out of reach. We raised this with the registered manager, who told us cleaning staff must have tied the call bells so they did not get in their way whilst cleaning. However, one of the bathrooms with a tied call bell had not been cleaned and so this explanation was unsatisfactory.

We noted on day one of the inspection one fire call point had been taped over. This was discussed with the registered manager, who immediately ensured the tape was removed. Staff were asked how long the fire alarm had been covered, and advised during works completed by an external company. It was unclear when this was, although was reported to have been in excess of two weeks. Similarly, one communal corridor had required electric work, including the replacement of a light fitting. A hole of approximately four inches by two inches in one wall had not been filled in. Live wires attached to the light fitting were both visible and accessible. The wall was a sensory wall, which encouraged people to touch the various items placed on it. The work had been completed over two weeks prior to the inspection. However, no action had been taken to address the risk of harm to which people were exposed. This was rectified by the end of day one of the inspection. In another corridor a light fitting had been removed, leaving a bulb on display. This was hot to touch. We spoke with the registered manager, who ensured this was remedied by the end of the day.

We further noted that several doors were damaged and unlockable, with fittings in the communal bathroom not working appropriately. No signage was placed on the doors to advise that the facilities were out of order, nor were the rooms secured. By day two we found appropriate action had been taken.

On days one and two of the inspection we saw falls safety mats with items placed either on or under them, which could cause harm to people, should they fall. This included for one person a metal alarm clock, a jug of juice, and a pack of sweets. For another two people we saw the legs of bedside trolleys tucked under the mat restricting the area that the person could safely fall on. We noted that this was rectified when raised with staff. However, on day two of the inspection, staff were spoken to on four separate occasions by two of the inspection team and the registered manager regarding unsafe practice with the crash mats for one person. The service sought advice from a professional regarding correct management and positioning of crash mats, prior to day three of the inspection. No further issues were noted. We had also noted on day one,

that one of the falls safety mats currently used had wiring exposed. This was a potential risk to the person should they fall on the exposed area. This was immediately rectified with a replacement mat.

We noted during the inspection the first and second floor had significant water damage to ceilings. On the second floor this had led to plasterboard breaking away from the ceilings exposing the rooms to rainfall. The laundry room, one treatment room (containing medicines), and several bedrooms were affected. The bedrooms were locked and out of use, although they were being used as additional storage facilities. However, the laundry room and treatment room were left exposed to the elements. This was being managed by using large mop buckets placed on top of the industrial washing machines and containers to collect any rainfall on the medicine cabinet. We spoke with one staff who advised they asked male care staff to remove the buckets when they were full, as they had dropped a full bucket of water, when trying to remove it themselves. They reported that this was not a safe management strategy. However, although the management were aware of the risks, no action had been taken to address this. We spoke with the maintenance man regarding the leak, who advised that this issue had been handed over to the provider in August 2017. We were told three-quarters of the roof required removing and relaying due to the leaks in different areas of the building. The registered manager acknowledged both points. We tried to determine why the roof had not been repaired, and were told that contractors required it to rain to assess where damage was, although the visual damage clearly indicated where the problem areas were. We asked the provider for a chronology of action taken by them to resolve this issue over the last 12 months. However, this information was not provided when asked during the course of our inspection.

We were concerned the risks associated with the practice of using mop buckets to catch rain fall had not been assessed, given the presence of electrical wiring behind the washing machine. Furthermore, the fact the water had caused visual damage to the first floor ceiling, meant the safety of the electrics between both floors was potentially compromised. This put people and staff at significant risk of serious harm. The fire risk assessment and health and safety risk assessments, dated 28 February 2018 both failed to address the leak, therefore did not detail what action was needed. Neither the registered manager nor the operations director recognised the significant risk the water posed to the electrics, when this was brought to their attention during the inspection.

On day three we requested an electrician be called to the service to complete an independent audit of the risk. This identified that whilst the ceiling was dry (no rainfall) there was no immediate risk. However, the recommendation was to repair the roof urgently, as rainfall would compromise the safety of people as the water would seep into electrics. Whilst awaiting repairs, the registered manager's proposed response to the potential risk, was to turn off the electrics from the fuse box should it rain. We were told that contractors would be called and all remedial work would be actioned within one week.

We returned to the service on 17 October 2018. We had been told by the registered manager that repairs to the roof and ceilings had been completed on 11 October 2018. We found that the ceilings of both the laundry room and treatment room had been fixed. Although the latter was visibly bowed, with signs of cracking. We asked the maintenance man why this was, and were told this was most likely a result of the plasterboard being damaged due to the rainfall, which had not been replaced. We checked to see if the other rooms had been repaired. We found the holes in ceilings remained. In one room, we found the carpet was significantly wet. We spoke with the registered manager, seeking clarity on why all repairs had not been completed. We were told that as the rooms were not in use, this was not seen as priority. We pointed out that the carpet was wet. Further it was apparent that the water had seeped through to the first floor. Water damage could be seen around many light fittings in communal areas. Whilst this was acknowledged, the registered manager reiterated that people were not at risk of harm, failing to recognise the potential risk.

People were not always being kept safe by staff at the service. Whilst some of the risks were not imminent, they were consistently present in different aspects of the care provision, which could lead to serious concerns related to people's safety. We spoke with staff to ascertain their understanding of how risk was managed and measured and were referred to the use of risk assessments. However, we were unable to see evidence of documented risks having been understood, assessed and mitigated for people residing at the location. This included risk of falls, urinary tract infections or skin integrity, as well as specific risks such as mental health issues or specific behaviours. A risk assessment is a document that aims to provide details on how to manage behaviours or concerns that may identify as risks for people. The assessment should detail when the risk is more likely to occur, and consider measures that can be implemented to minimise the risk. The majority of the people who used the service were at risk in multiple areas. It was therefore crucial that staff were aware of how to manage these risks, as their impact may be significant for people.

For example, one person who was non-verbal, with no mobility, and is doubly incontinent was unable to alert staff to requiring a pad change. This increased the probability of developing skin problems. Similarly, a person who required food to be produced in a pureed consistency, and has limited mobility would require being positioned in a way to ensure they are able to eat their food safely, without risk of choking. If staff are unaware of how to seat the person, this can lead to digestion problems as well increase the risk of choking.

In another example, a person whose behaviours posed significant risk of harm to others, (as detailed in pre-admissions documentation,) had no risk assessment, adequate care plans or measures in place to mitigate the risk. This was reported on days one and two of the inspection, with a comprehensive discussion taking place regarding the safe management of the person with the registered manager. By day three of the inspection whilst immediate measures had been taken to mitigate the risk, there was still poor understanding of the actual risk of harm to others. We were told by the registered manager the risk was low, as no incidents had taken place at the service. We raised concerns that the person's pre-admission information very clearly stated the person would settle in their new environment, prior to the risk resurfacing. Information also described the behaviour as opportunistic, and therefore it required a proactive management strategy, which was not in place. Within pre-admissions information the risk was described as high, with very specific guidelines set out, should the behaviour occur. However, this was neither understood nor recognised as a risk by the registered manager. The lack of clear documentation for risks meant that staff may not be fully aware of the most appropriate way to manage the risk, or that a risk even exists. The service had placed others at significant risk of harm by not ensuring the precautionary measures were in place, as per guidelines during the first two days of inspection. We were given an explanation for the absence of the stated precautions but no alternative measure had been put in place to mitigate the risk.

It was unclear whether any incidents had occurred because of the absence of accurate documentation, because records were not maintained appropriately by staff working at the service. For example, we found that repositioning sheets for four people indicated that they had not been repositioned in line with their care plan. We noted gaps of six hours, eight hours and five hours for one person, which were not consistent with the care plan. Similar discrepancies were present in other people's repositioning sheets. It was unclear whether this indicated poor recording or whether people had not been repositioned as required. We spoke with the registered manager and clinical managers regarding the poor documentation to establish if this was accurate. They were unable to clarify. We were told by the registered manager that she could not check all documents due to the high number of people residing at the service. Random samples were reviewed during the daily walk around, however the audit tool used, failed to identify whose records were checked and whether any discrepancies were noted. This therefore meant that information may not be appropriately passed on to staff, and rechecked accordingly.

We noted people had records maintained of their food and fluid intake. However, this information was not

monitored to ensure people received sufficient nutrition or fluids. For example, one person was drinking between 600-850ml of fluid daily. There was no daily target fluid intake recorded nor was their total intake recorded daily. We spoke with the registered manager and clinical managers regarding this and were told that most of the people had a fluid and food intake sheet in place, however this did not serve an actual purpose. We requested further information on whether for this person, this information was necessary, and they were unable to clarify this. It was unclear if any analysis was completed, to determine where people were becoming unwell.

Daily records were archived on a weekly basis which meant these were not easily accessible to be monitored to identify potential concerns, or cross referenced against existing care plans. Staff were required to make handwritten notes in weekly records. Body maps, skin integrity checks and records pertinent to health, including weight checks where applicable, were to be noted. However, we found staff were not appropriately keeping these records.

For example, we noted, one person had lost approximately 10kg over five weeks. As a result, the person was meant to be weighed weekly. However, weekly weight checks were not completed. In another example, we found a weight loss of over 14kg within 17 days. Upon speaking to staff about the significant difference, we were told they believed the second weight was incorrect. However, the person had not been weighed to check their actual weight for one month, despite the service requiring this information to set the pressure mattress to an appropriate pressure. This person was weighed on day two of the inspection as a direct result of our prompting. An additional discrepancy in weight was identified. This illustrated an increase in weight by almost seven kilograms in six weeks, which was unexplainable by staff. We noted the pressure mattress was set to too high a pressure, which put the person's skin integrity at additional potential risk. No records were maintained in the daily paperwork to record and check weight settings for people who were at risk of skin integrity issues due to poor mobility. The registered nurse on shift told us they assumed the weight on the machine had been altered by another resident who had entered the person's room. However, there was no evidence of this. No recording was available of any such incident, nor of other incidents described by the nurse as altercations between the two people which were reportedly quite common. This meant incidents related to people were not being appropriately monitored or analysed. Therefore, no system was in place to establish how to minimise and prevent similar occurrences. The service did however complete falls analysis that focused on when and how falls occurred, attempting to reduce the probability of these in similar circumstances.

We case tracked 14 people, looking at their files in relation to their needs. We also reviewed their medicines, and daily records. For two people we noted they required medicines to be given covertly. This should be agreed and authorised as a best interest decision, if the person is assessed not to have mental capacity associated with medicine compliance. This process requires the agreement of appropriate health professionals. The latter then provide written guidance on how the medicine needs to be given. We saw no records of best interest decisions having been made for either of these two people. We sought clarity from two nurses, who were unable to advise on the correct process that was to be followed to administer these medicines covertly.

We checked people's topical creams, and were advised these were stored in people's rooms. However, for one person their cream could not be located, although had been signed for as having been applied. For another person, the family had purchased an over the counter topical cream providing this to the home for staff to apply. Staff were unable to advise of the service policy in relation to accepting such 'homely remedies'. We saw two people had ointments placed next to their drinks in their rooms, within easy reach. We spoke with staff regarding the poor placement of medicines. These were removed immediately.

During the inspection we observed several medicine rounds. Medicines were kept securely in a medicine trolley that was stored in a temperature controlled medicine room per floor, in each unit. On all floors of the service the registered nurse (RGN) was tasked with administering all medicines. We generally observed safe administration practice. The RGN correctly checked medicines across medicine administration records (MARs), ensuring dosage, time and name of person were correct. We checked 20 records and found no errors. Guidelines for as required medicines (PRN) were in place for all people who required PRN. These clearly illustrated when these were to be administered and what dose. We did note during one lunchtime medicine round, although a red "do not disturb" tabard was worn, the RGN spoke to a visiting professional for a significant period, during medicine administration. We spoke with the RGN and visiting professional, who acknowledged this was poor practice.

The service employed a number of domestic staff to ensure the service was clean and prevent risk of infection. We found on day one of the inspection that bathrooms had not been cleaned for six days. The daily cleaning schedule clearly illustrated this point, as did the visual condition of the rooms. However, this had not been picked up by the registered manager or staff. Bathrooms were visually unclean. Bath tubs had rusty residue along the rim of the bath, with embedded soap residue. Toilets had faecal matter smeared on the inside rim, with pungent odours coming from the rooms. On one wash basin we saw a brown smearing to the outside of the basin. Bedrooms carpets were dusty and dirty. The floors were sticky with pungent odours coming from all but one unit. Toilet rolls were placed on the toilet water tank, therefore not in reach of people. Some bathrooms did not contain any soap or hand towels. We spoke with the registered manager regarding this. They acknowledged the service was "unclean". However, appeared unable to see how this could lead to infection control risks. By day two all units were cleaned, with bathrooms appearing immaculate. On day three we noted that one bathroom was again not clean. One floor was using air fresheners to mask a pungent smell or urine. This was not used sparingly, which could have exacerbated respiratory problems. During our visit on 17 October 2018, we found that the service was again not clean. Bedrooms and units had extreme pungent odours of incontinence. No measures were taken to air rooms.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured the people were always kept safe. The provider had not done all that was necessary to mitigate any such risks related to the safe administration of medicines and preventing, detecting the spread of infections. The premises were not safe, and risks were not assessed appropriately.

People were not kept safe by the provider's current recruitment processes. The registered person did not operate effective and robust recruitment and selection procedures to ensure they employed suitable staff. We reviewed the files of 12 staff who worked at the service and all the files were missing some required information. Gaps in employment were not verified or checked, and reasons for employment termination were not identified. Two staff did not have evidence that they were of good character. One staff member's name did not match that on their DBS. A DBS enables potential employers to determine whether an applicant has any criminal convictions that may prevent them from working with vulnerable people. Whilst all staff had health declarations in place, where risks were identified, we were not shown what measures the service had taken to keep both staff and people safe.

The provider's recruitment practices meant people were at risk of having staff providing their care who may not be suitable to do so. This was a breach of Regulation 19 and Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not established and followed recruitment procedures to ensure the suitability of staff employed.

Staff spoken to during the inspection could describe different types of abuse. One staff told us, "If I saw anything (of concern) would report straight to nurse or clinical manager or RM [registered manager]." We

were told that, where applicable, staff would not hesitate to whistle-blow. Part of the inspection intelligence was gained through staff whistle-blowing. We spoke with the local authority safeguarding team who advised they were correctly notified of any potential safeguarding concerns. We also received notifications within an appropriate timeframe advising of any concerns.

We noted that staffing numbers generally appeared adequate across the service. This was calculated using a dependency assessment tool based on people's needs. One staff told us, "Have enough staffing, all right staffing". The service did not use agency staff.

The provider had a business contingency plan in place detailing what action needed to be taken in the event of foreseeable emergencies. Examples included adverse weather conditions as well as staff shortage due to illness. Emergency contact numbers were included within the contingency plan, as well as what staff should do if any issues arose at the premises.

Requires Improvement

Is the service effective?

Our findings

People's hydration and nutritional needs were not adequately met by the service. We looked at whether people had enough to eat and drink. During our inspection, we observed some people had drinks left out of reach and that a significant number of people were unable to drink without assistance. We looked at a sample of people's fluid intake over the course of a few days. We noted that no target fluid intake was noted on any of the five files we looked at. Furthermore, the fluid intake was generally between 450ml – 850ml for all five people. This point was discussed with the registered manager and the clinical managers, all of whom were unable to advise what the target fluid intake should have been. We were told forms were completed for all people who resided at the service, irrespective of need. The records we looked at were specifically for people who were at risk of pressure sore development and had poor skin integrity, therefore recording fluid intake would be required. It is crucial for wound healing that people have sufficient intake of fluids. However, because no one had individual fluid targets in place based on their weight and healthcare needs, there was no way of ensuring people's individual hydration needs were met.

During the inspection we completed observations over lunchtime. We saw staff assisted some people to eat their meals, where required. We also observed people who had fallen asleep whilst eating, were not encouraged to eat independently, or where families were told that the person "…did not like that," with no alternatives offered. During our SOFI (short observation framework observation) we noted one person had a meal left in front of them when we entered the communal room. They were sat alone, and had fallen asleep. Another two people were sat with one staff. One was being assisted with eating whilst the other looked on. Interaction was limited. Eight minutes into our observation a member of staff entered and took the cold pureed meal to try and assist the person who had been asleep. We interjected and advised that the meal was cold. The staff member took the plate away returning with a fresh plate. This contained pureed food, however was totally covered in gravy. We observed that several other people had pureed or softened food that had gravy poured over it. This raised concerns over the consistency of the food being altered from that required by the person which could lead to an increased risk of them choking. We spoke with the staff regarding this on day two. We were told on day three of the inspection that this did not affect people's ability to swallow safely, as conversations were had with the chef, who advised the guidelines they had been given. Although, we were not shown any evidence of this being recorded.

People were not given accurate meal information on day one of the inspection. The menu detailed a different meal than what was given. In addition, only one food option was offered. This issue was noted on all three days of the inspection. We received mixed feedback regarding the food. One person said of the food, "Very good, food's brilliant, eat very well here, they change it every day." Whilst two relatives reported concerns about the poor food offered and the risks associated with how people were assisted. This included people not being sat in the correct position, beds not being raised, and people having pureed foods mixed together.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service offers specialist dementia care across all floors, although the level of dementia may differ considerably per unit. We found that whilst some units had commenced dementia friendly practice this was not consistent across all units. Bedrooms generally appeared de-personalised, memory sheets outside bedroom doors had varying levels of information noted within them. Signage although used on some units, was positioned too high on the wall for most people using the service to be able to read or see. This was inconsistent, which could lead to further confusion. Toilet seats for communal facilities were not in a contrast colour, which could help people to locate the toilet. The communal lounges did not lend themselves to dementia care. Seats were arranged along the perimeters, heightening the potential for poor socialisation. Table settings did not focus on the needs of people with dementia. The cutlery and plates used did not promote independent eating. People were not being engaged by the activities co-ordinator or generally by staff. People appeared isolated when sat within a communal setting. The corridors offered little information of interest, although it appeared staff had tried to commence creating sensory walls. We found one seat had been placed in one of the corridors allowing a person to sit, although no additional activity was available in this location. Furthermore, staff used this area to place large hoist charging batteries.

People were cared for by a staff team that had some understanding of the principles of the Mental Capacity Act 2005 (MCA). All staff employed had received training in the MCA, as this was defined as mandatory training. The 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We found that DoLS applications had been requested as required by the registered manager.

People were cared for by a permanent staff team that had received supervisions from their line managers at frequencies varying between three monthly to six monthly. We were told staff could approach their line manager as required at any time between supervisions for support. Staff training was reported at 100% with training delivered internally by a trained trainer as well as through e-learning. We noted the training did not cover areas such as Equality Diversity and Human Rights and dignity and respect. We were told this was covered as part of the Care Certificate that staff were required to complete as part of their induction. The Care Certificate is a set of 15 standards that are used to assess staff knowledge, skills and behaviour when working with people within a care setting. The Care Certificate is used as part of best practice guidance We were not shown any evidence of the Care Certificate having been completed. No records were shown that illustrated when this was commenced and how long staff took to complete the certificate, although this was requested. . Team meetings were held quarterly with staff attendance set as mandatory.

People reported staff sought consent before completing personal care, although from our observations they were generally task focused. They said, "They do ask, but often don't have time to complete the task properly. I haven't had a bath for one week." A relative said, "they ask but they are rushed off their feet." We spoke with the registered manager about this and queried whether sufficient staff were employed per floor. We were told that a staffing tool was used to ensure sufficient staff were employed. We found that initial assessments had been completed in all files case tracked. However, care plans were not reflective of the initial assessments nor were daily records. This meant people were not always receiving effective care.

People received some effective health care and support. People could see the visiting GP and other health professionals such as physiotherapists, speech and language therapists as and when required. Although, it was recognised that at times the referral process included extensive delays. leading to continued health problems.

Requires Improvement

Is the service caring?

Our findings

Staff could correctly describe how they would preserve people's dignity when assisting them with personal care. Staff told us they would knock or call out to the person before entering the room, and explain what task they were going to complete. However, we observed undignified care and treatment of people on three separate occasions by three separate staff. In one example we observed staff speak about a person in an undignified way, shouting out personal information as they walked in the communal corridor. They were unaware of our presence nearby. In another example we observed one person was not clothed, and was covered by a sheet. Their bedroom door was left open. We approached staff and alerted them to the person. The staff entered the room, and tried to put a top on the person. The bedroom door was left open during this process. We also noted staff very rarely knocked on people's doors. Most doors were left open with reasons being given that the person did not like it to be shut, although there was little documented evidence to confirm this in the care plans. By leaving the doors open all the time, people did not have their privacy and dignity maintained on their behalf. The service failed to consider effective ways to maintain people's dignity where necessary, when in their bedrooms.

Observations were completed during both days one and two of the inspection on both the first and second floor during lunchtimes. On the second floor we focused on four people, three of whom required support with eating. The staff who were assisting offered task focused support. We observed little or no communication between staff and people. People were not asked before being offered a mouthful of food, nor were they asked which element of the meal they wanted to eat.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's right to privacy and dignity was not maintained.

There was little evidence that people were communicated with using their preferred method. Care plans contained minimal information in this area. Staff were observed to repeat questions or makes decisions for people. In one example, a member of staff who was assisting a person with eating told the person, "Good girl" and kept repeating, "Can you swallow it?" The person was observed to cough frequently and staff asked them, "What's the matter got a tickly cough?" The care records showed the person had been assessed by the Speech and Language Therapist in the past and had a known difficulty with swallowing so the staff interaction was not skilled and failed to show the person dignity or respect. Furthermore, their lack of knowledge of the person's needs illustrated uncaring practice.

We did see some evidence of caring interaction. Some staff were observed smiling throughout interactions with people and using touch appropriately to offer reassurance. One relative reported that the interaction was positive, however the way in which their person was supported was not always caring. They reported the staff would assist as though it were a task, ready to move onto the next person.

Relatives told us they had not been directly consulted about their family member's care plans or reviews. Two relatives we spoke with were concerned about the ramifications of speaking with us. We were unable to gain further information on why they felt this as neither relatives were willing to speak with us further.

In general, people's right to confidentiality was maintained. We found staff spoke with respect and privacy regarding people. They would go to an empty room (e.g. dining room or lounge), office or stand to the side of the corridor and speak in a low tone when discussing people. However, we found daily records were kept in people's rooms with "confidential" written on them. We were told these were confidential records which could only be accessed through authorisation and agreement of the management. These were easily accessible, because bedroom doors were generally left open.

Inadequate

Is the service responsive?

Our findings

The service was not responsive to people's needs. Care plans were inadequate and did not provide sufficient information to ensure that support met the needs of people living at the service. For example, where people required two staff to support with moving, details were not given about which sling was to be used and how this should be done. In another example, the care plan did not document the frequency of supporting people who required assistance with incontinence. We found one file had conflicting information about whether a person was continent or incontinent, and the level of support required with this aspect of care. We went to the person's room, and found they had had issues with their continence. We were told by the maintenance man the carpets needed to be removed and more appropriate flooring laid. However, this had neither been authorised nor a date assigned as to when this work would be completed. The person was left in a bedroom that had saturated carpets. The smell was very strong and no ventilation had been arranged to air the room. For another person who was diagnosed with Parkinson's disease, the care plan failed to recognise how this could affect their health. No care plan or information on how to manage this was documented or available to staff. This potentially put the person at risk of health issues.

The care plans that had been written were not person-centred. They contained minimal information and did not address how the person wished to be supported. Information appeared to be sparse, irrespective of whether the person could provide it themselves or were reliant on family to provide it. Records were hand written. This caused further issues as some handwriting was illegible. We addressed this with the registered manager, who acknowledged that care plans did not contain sufficient information at present. Documented reviews were not an accurate reflection of people's changing needs. For example, one person who had lost a significant amount of weight was due to be weighed weekly. The care plan although signed off as reviewed was not cross referenced with the actions of the Malnutrition Universal Screening Tool (MUST), that identified the need for weekly weighs. As a result, the person had not been weighed as required. Staff were therefore unable to determine whether or in what way the person's weight had changed, and what responsive action was necessary.

Care plans did not demonstrate how people or their representatives had been involved in planning their care. We found one person who had come into the service initially on respite, remained in situ and had now become a permanent resident. They were unhappy with this decision, and advised that staff were not providing them with care that was responsive to their needs. They spoke of not having their health needs met, referring to a particular skin condition which had been an issue for over two weeks. We spoke with the registered nurse who seemed unaware of this issue. We checked the person's records and found the initial assessment documented "dry skin". No care plan had been developed around how to manage the dry skin. The nurse on shift was unaware and failed to advise that the person also had eczema, and was on medication for this. The family had purchased a topical cream and provided this to the home, to apply as required. There was no record that this has been applied.

We found that staff understanding of dementia was limited, although the training matrix indicated all staff had completed training in dementia. For example, we spoke with one nurse about several people who walked the corridors. We asked why this was, and what activities, if any had been encouraged, for example

walking the external grounds. We were told that the person did not venture to the grounds as staff did not take them. Further it would not benefit them, "…as they have dementia". The information within this person's memory sheet detailed that this person enjoyed trekking. The activities offered were not personalised to people or reflective of people's needs. Some were generic and repetitive often geared towards one unit only. In addition, the details on the activities sheet were not a true reflection of what was being offered. One person's care plan said they enjoyed yoga, and this was also written on the sign on their bedroom door. We asked staff whether the person ever had the opportunity to do yoga, and they told us they did not and did not know why it was in the care plan. Consideration was not given to exploring this further, or to reviewing the person's care plan, if inaccurate.

A relative we spoke with told us, "[name] often doesn't see the staff unless they come in to help with personal care." A person we spoke with told us, "It would be nice if they popped in for a while, but I know they are busy." The home was generally not making relevant alterations to accommodate the changing needs of people and there was no evidence of guidance on best practice for people living with dementia having been sought. The staff were unaware of how to engage people informally in the course of their daily tasks.. We made numerous observations during the inspection and found that staff were unaware of methods of engagement. For example, we saw on several occasions people seated along the perimeters of the communal lounge. The TV was on, but no one was watching it. People sat in chairs were either asleep or appeared disengaged. Staff when present, remained silently seated. This meant people's social needs were not met.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not in receipt of personalised care that was responsive to their needs.

People and their families were aware of how to report a complaint or a concern, but were not always confident that this was responded to appropriately. The service had documentation in place that illustrated when a complaint was received, and what action had been taken to investigate it. We found the written documentation clearly defined the process undertaken by the registered manager when dealing with complaints. It was acknowledged people and their relatives may not always be satisfied with the outcome of the investigation.

At the time of the inspection two people were on 'End of Life' (EOL) care, although the service chose to refer to this as TLC. Because of the confusion with names, when we requested information on whether anyone was on EOL we were told "no" by staff. Staff were unable to identify to us who the two people were until after they passed away. We spoke with the staff in retrospect, and asked how they managed this. Staff could explain the necessary care for people on end of life, including pain management and the use of" just in case" drugs.

Staff had not received training in equality, diversity and human rights. Practice was not reflective of the principles of this legislation.

Inadequate

Is the service well-led?

Our findings

We found that the service was not well-led. Part of the role of the registered person, is to ensure they have a full overview of the service. This is achieved through good governance. Whilst the registered provider had ensured a registered manager was in situ. They had failed to ensure the manager had the necessary knowledge and skills to ensure compliance with regulations. We found the registered manager did not have a clear understanding of their responsibilities, and were not supported appropriately by the registered provider.

The registered manager and clinical managers did not have a shared understanding of the key challenges, concerns and risks present at the service. We found many of the issues we identified had been overlooked or were downplayed. For example, the serious issues surrounding infection control were referred to as, "The home was untidy". When we advised this was not about being an untidy provision, but a service where people were placed at significant risk due to the lack of cleaning, this was again downplayed. Schedules were provided that showed cleaning had been completed. Upon closer examination the cleaning referred to vacuuming only. We referred this back to the registered manager, who had accompanied us on the tour of the premises, and was therefore fully aware of the issues.

Similarly, where call bells were tied out of reach, these were being untied by the registered manager. We were told that this was not an issue, as people could not use the call bells, or that staff would be present with people when in bathrooms. We queried what measures were in place for people who could not use a call bell, and how this was measured, but did not receive a satisfactory response. We advised that whilst a member of staff may be present, a person may still fall, and staff require additional support. Having call bells tied up meant people or staff may not receive immediate support should they require this.

The registered manager did not have an accurate understanding of risks associated with people. One person whose behaviours were identified as high risk by the probation service, was seen by the registered manager as low risk. Their assessment was deemed accurate as no incidents had occurred at the service. The registered manager failed to take into account the serious nature of the behaviours, and that the person had been shown to have a "honeymoon period" before the concerning behaviours start. The risk assessment was subsequently reviewed. We were provided with a copy of the person's file on day three, and told this had been updated as necessary. We found two copies of risk assessments for the same behaviour dated 28 September 2018. One still rated the behaviour as low, whilst the other now rated the behaviour as medium risk. The registered manager had not reviewed the file although they were aware that it would be rechecked on day three of the inspection, following our concerns.

We found the registered manager continued to fail to understand the high risk of having a leaking roof, and the potential damage and risk this posed to the electrical supply. This was despite the feedback received from two independent electricians, which clearly advised the roof needed to be repaired urgently and should it rain, the electric supply needed to be turned off at the fuse box. The registered manager stated that work was not essential as rooms where holes in ceilings remained were unoccupied. The registered manager did not understand the impracticality of switching off electrics should it rain, and the potential risk

to life should the water reach electric cables.

During the inspection we found the registered manager was unable to answer many questions related to the day to day operations of the service. It was recognised the service is large, however, it is important for the manager to have a thorough overview of the provision. It was apparent the registered manager did not have a complete understanding of the service's shortcomings. For example, they were unaware that many of the documents related to care were either inaccurate, incomplete or misunderstood. Further, they were unaware of documents that existed to monitor things, for example water temperatures, and as such had not ensured these were completed. We did not see sight of an action plan that had been created to capture all areas of concern within the service and how and when these were to be completed by.

We found that whilst staff provided care to people, accurate records were not always maintained or did not accurately reflect the support people were being offered. This neither demonstrated good care nor illustrated how changes to people's needs were being managed, if at all. There was a risk that any new staff, coming to work at the service could provide ineffective and unresponsive care, by following insufficient care plans. We were told audits of care files and daily recordings were not completed due to the high number of people residing at the service.

We were provided with maintenance records, that were to detail checks completed weekly and monthly by the maintenance man. These were forwarded to us following the inspection. Records were signed off by the registered manager, as having been audited.

Fire safety checks had been completed as appropriate. This included, fire equipment checks, panel checks, sounding the alarm and practice drills. Personal emergency evacuation plans (PEEP) existed for people on all the floors. The local fire service had not completed an audit of the service. However, the provider had commissioned an external company to complete both fire risk assessments and health and safety assessments. Both were lengthy documents, although generic, failing to take into consideration the service type. More concerning, neither assessments had referred to the leak in the roof and the potential risk this presented. Furthermore, the registered manager had signed off both risk assessments as being reflective and accurate of the service. The registered manager had failed to update the risk assessment as the water damage to the premises continued.

The service had a cleaning schedule in place. The housekeepers signed to indicate when each task had been completed. We found the bathrooms had not been cleaned for six consecutive days, leading to concerns around infection control. The registered manager was unaware of this, as no audits of the cleaning folder had been completed. We were told daily management walk around were completed. However, these had failed to highlight any of the issues that were identified by us during the inspection.

Audits were completed intermittently. This meant the registered manager did not have a true awareness of the issues. For example, Individual care plan audits were completed in May 2018 and June 2018. This is when random files were selected by the registered manager and reviewed. No action plan was generated and no further reviews took place. Similarly, medication audits were completed in February and April 2018, with no evidence of additional reviews. We saw evidence of three, night time audits having been completed in January, April and July 2018. These highlighted many issues however subsequent audits failed to illustrate how these issues were resolved. For example, the audit of 24 April 2018 at 03.30hrs identified that "In Kingfisher and Peacock all lights were on as residents were moving up and down the corridor." The action from the April audit and July audit failed to assess why potentially a total of 37 residents were awake and moving around at 03.30hrs, and what affect this was having, if any on their health.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, that specifically focuses on good governance.

We found that CQC had appropriately received notification of notifiable incidents, including DoLS applications, allegations of abuse and serious injury. Where a person has sustained injury, the service is required to comply with the requirements of the duty of candour. This legislation aims to ensure that the service is transparent and reports openly on care and treatment. It further reinforces the need to document investigations where appropriate, providing an apology when things go wrong. We found that the duty of candour had not been followed through on in several incidents where people had sustained injury. The registered manager was unaware of the need for written notification. However, upon being shown a copy of the regulation it was agreed that this had not been carried out. The registered manager assured us that moving forward the duty of candour would be evidenced.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, that specifically focuses on the duty of candour.

Staff reported that the registered manager was friendly and approachable. She had an open-door policy, and would visit the various units daily. However, staff acknowledged the service was stagnant and there had been little development and progress. One clinical manager referred to the inspection process as, "A pair of fresh eyes". The registered manager acknowledged all the issues that were identified during the inspection but was unable to put forth a plan on how these issues were to be resolved. We were told that a deputy manager post would be created and that this would decrease the burden on the registered manager. They would then have an opportunity to deal with some of the issues. However, the registered manager recognised that the task ahead was difficult.

The service had not yet completed quality assurance audits or surveys, although did speak with people seeking feedback. Relatives meetings were arranged annually to promote openness and transparency, with relatives also invited to the biannual residents' meetings.