City of Bradford Metropolitan District Council

Valley View Court

Inspection report

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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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Valley View Court is a specialist care home service without nursing, providing personal care and rehabilitation for older people, some of who are living with dementia. The service is registered for up to 50 people and at the time of inspection there were 42 people using the service. Valley View Court provides support to people living with dementia through the short-term cognitive impairment assessment beds, as well as rehabilitation support through the rehabilitation and escalation beds they have available.

People's experience of using this service and what we found
People were not always safe. People were at risk of harm as the provider had not identified, assessed or mitigated risks. This included risks related to people's health and care needs. Medicines were not managed safely.

People did not always receive person-centred care and care records did not fully reflect their needs. Although some staff were kind, caring and compassionate and treated people well, other staff were task focused and did not respond appropriately to people's needs. There were limited activities taking place and there was little to occupy and interest people.

Staffing levels were not always sufficient to meet people's needs, with a high reliance on agency staff members. Agency staff were not always provided with a robust induction to the service or allowed time to read care plans and get to know people's requirements. Staff training was out of date for subjects specific to the needs of people using the service, such as dementia and rehabilitation.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests.

There had been a recent change in leadership. The governance structure was ineffective which meant the service was not appropriately monitored at manager or provider level.

Staff received an induction, shadowing and support they needed for their roles, and the recruitment process prior to employment was safe and robust. The premises were clean and hygienic and infection control procedures were followed by staff as personal protective equipment (PPE) was worn correctly.

People were supported to keep in touch with family and friends through phone calls and indoor visits. People had access to healthcare services. People were provided with a good amount of food and drinks.

The registered manager and provider were responsive to the inspection findings. They took action after the inspection and shared plans to improve their systems and processes.

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

Rating at last inspection
This service was registered with us on 25 October 2019 and this is the first inspection.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found the provider needs to make improvements. Please see all the sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Valley View Court on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to medicines, managing risk, safeguarding, mental capacity assessment principles, staffing and good governance 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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Valley View Court

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out on the first day by 3 inspectors, a medicines inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day of the inspection 2 inspectors visited the service.

Service and service type
Valley View Court is Care is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Valley View Court is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced. Inspection activity started on 01 November 2022 and ended on 18 November 2022. We visited the location on 01 and 03 November 2022.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We reviewed information we had received about the service and sought feedback from the local authority commissioners and safeguarding team. We used all this information to plan our inspection.

During the inspection
We spoke with 6 people who used the service about their experience of the care provided and 4 relatives. We spoke with 14 members of staff including the registered manager, deputy manager, senior staff, care staff and agency care staff. We reviewed a range of records. This included 11 people's care records and multiple people's medication records. We looked at 3 staff recruitment files and a variety of records relating to the management of the service, including policies and procedures.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
● Information regarding people's allergies was not always recorded across all documentation. This meant there was a risk people might be given medicines which they have previously reacted to.
● Instructions for medicines that were given when required, were not always available to inform staff when they were administering medicines. When instructions were available these did not always contain any person-centred information. For example, a medicine prescribed for anxiety did not give staff any information on when to administer.
● For one person being given their medicine covertly in food and drink, there was no information for staff on how to do this. This meant that medicines may not be administered safely. There was no assessment available for this person to show giving medicines covertly was in their best interest.
● Where people were able to administer or look after their own medicines, there were not always adequate risk assessments or safety checks in place.
● The provider's medicine policy had passed its review date. This meant we could not be assured that staff were following the most up to date guidance around medicines.
● There was insufficient evidence medicines were being stored at the right temperature for them to be effective.
● Staff were trained to support people with their medicine, although there was little evidence of robust checks of their competence, to make sure practice was safe.

We found no evidence that people had been harmed however, systems were not in place to ensure medicine management was safe. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were stored securely.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
●Risks to people were not assessed and managed safely.
● Where risks had been identified, actions had not been taken to ensure people's safety. People who were known to be high risk of falls and had recently fallen did not have any assessment for equipment, such as sensor mats. This meant staff were not aware when people had fallen.
● Risk assessments were not always in place when they were needed. For example, some people did not have nutritional risk assessments despite their care plan identifying them as being nutritionally at risk.
● Nutrition and hydration intake were not always accurately and consistently monitored where people had been identified as nutritionally at risk. We found examples where there were gaps in documentation of

people's food and fluid intake, and no daily calculation for amount of fluids received.
● People's weights were not being monitored. We identified people who had recently lost weight and were known to be nutritionally at risk, however, we saw no action was taken to address weight loss, investigate the cause or make appropriate referrals to other health professionals.
● Care plans did not contain sufficient details around people's continence needs and requirements. This meant there was no guidance to staff on what specific continence equipment people used and how often they needed to support them.
● Not all accidents and incidents were reported, investigated or dealt with appropriately. Some incidents were not being recorded or reported by care staff which meant the registered manager was unable to audit these events and could not take action to reduce risk of future occurrences.
● Accident and incident analysis reports did not identify lessons to be learned and actions to be taken to prevent a recurrence. The registered manager identified improvements were needed and was taking action to address this issue.

The lack of robust risk management processes meant people were not protected from harm or injury. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Systems were not in place to protect people from the risk of abuse and harm.
● Staff had recorded on body maps, some incidents where people had multiple bruises. However, there was no evidence to show the cause of these had been investigated or followed up by management.
●Care staff had completed their online safeguarding training however, several staff told us they did not know the procedure for whistleblowing.

The lack of action taken to investigate unknown bruises and act on concerns meant people were not protected from the risk of harm or abuse. This was a breach of Regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Safe recruitment practices were followed. Recruitment checks including references and criminal record checks were completed before staff started working in the service.
● Documentation was robust and detailed, demonstrating a thorough interview process.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● The provider was supporting relatives and friends to visit people safely. We saw people's relatives and friends were welcomed and could spend time with their relative where they preferred. The appropriate safeguards were in place to protect people regarding visitors to the service.

Requires Improvement

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Staff were not fully equipped to meet the needs of people using the service.
- The registered manager explained Valley View Court provided a dementia assessment service in three of the units. This was confirmed in the provider's Statement of Purpose. However, some staff said they had not completed dementia training. One member of staff said, "Here we would benefit from more specialist training around dementia." The training matrix showed 96% of care staff had not been provided with any dementia training.
- We found 60.5% of staff had not done rehabilitation and enablement training despite two units being specifically for this type of care.
- We received a mixed response when we asked about support for staff. Some staff said they felt well supported; others thought the support was inconsistent. One member of staff said they had only received one supervision session in the last year.
- The provider did not have enough staff to keep people safe and relied heavily on agency staff, some of who told us they did not receive inductions or handovers and did not know people's needs or requirements.
- Staff deployment was not always effective in maintaining safety due to the reliance on agency staff members. Some staff told us they had worked on their own on units due to the shortage of staff, when they should have another care staff member on the unit.

Staff had not received the support, training and supervision necessary for them to carry out their roles. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- New staff received induction training and shadow support prior to commencing employment.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). When people receive care and

treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

●The service was not working within the principles of the MCA.
● Mental capacity assessments and best interest decisions were not in place for some people despite having restrictions placed on them.

The provider had failed to ensure people's care and support was delivered in line with the MCA. This was a breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The admission process was not robust and failed to keep people safe. Staff told us they no longer used the checklist for admissions meaning care plan paperwork, in particular on the assessment units, was not completed in a timely way. We found people who had been recently admitted to the assessment unit did not have the necessary paperwork completed in the care plans within 72 hours as per the provider's process. We found one person who was high risk of falls, had been in the service 4 days. Their care plan and risk assessments were blank despite the fact they had already had two falls since being in the service.

The provider has responded since the inspection and informed us they are taking action to address the concerns.

Supporting people to eat and drink enough to maintain a balanced diet
●People had pleasant mealtime experiences and were provided with good amounts of food.
● People were offered snacks and drinks throughout the day and staff encouraged people to eat and drink.
● Feedback overall was positive for the food and drink provided. One person told us, "The food is good, nice, basic home cooked stuff."

Adapting service, design, decoration to meet people's needs
● The assessment units were specifically for people living with dementia; however, the living environment was not dementia friendly. Bathroom doors were a contrasting colour to help them stand out, although there were no other environmental adaptations made to support people living with dementia.
● The service had association boards in each of the units to display pictures relating to the time of the year for people living with dementia.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People's care records did not always show people received appropriate support with their healthcare. One person had been unwell, and staff said they thought a GP had recently visited. However, staff could not find any information in the person's care records to say whether they had received this support.
● People had access to the provider's own team of specialist clinical advisors including physiotherapist's and occupational therapists.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People's experience around how well they were cared for was varied. We saw some examples of caring practices, but we also saw staff did not always intervene even though some people were being unpleasant to other people using the service.
- One person was visibly distressed and cried throughout the day, most of the time staff ignored this and did not provide comfort to the person. This was discussed with staff on the unit who informed us the reason they got distressed and they would be fine after a visit from family. We were not assured by their response.
- One person was confrontational to another person using the service. Staff did not respond and left the lounge leaving both people alone together. This was discussed with the registered manager who was responsive and said they would look into this.
- We observed on some units there were occasions when staff did interact with people, it was done in a kind and friendly way.

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

- People were not always involved in day to day decisions about their care. Some staff members explained aspects of people's care to them and regularly asked if they were alright. However, on some units, people were not involved in decisions such as what they wanted for lunch and to drink.
- A relative told us, "I have not seen the care plan but have been informed by the social worker who has involved me in [relative's name] care plan."

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was maintained.
- Support was provided at mealtimes and throughout the day whenever people needed it. Staff members sat next to people who needed support with eating and provided this in a calm and caring way.
- People looked well cared for and staff had spent time supporting people to maintain their appearance.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plans did not always reflect people's physical, emotional and social needs. One person's care record showed they were frequently emotionally distressed, which included grabbing staff. However, they did not have a relevant care plan to help staff to understand how to support the person.
- Information about people's preferences or interests were not incorporated into the care plan even though some people had stayed in the service longer than the anticipated period of a few weeks.
- Care plans for people on the rehabilitation units were much more person centred and specific to people's needs. We found they were reflective of the discharge notes and assessments done prior to admission.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers', get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's communication needs were not always met.
- We found examples where care plans contained information specific to people's preferences, such as sight and hearing plans. One person's sight plan indicated they wore glasses and wanted staff to support them with ensuring they had these on at all times. We observed this person did not have their glasses on during our site visit.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Activities were done on an ad-hoc basis and not planned. We found on each unit the activities were limited and some people sat for long periods of time with little stimulation. We did see some activities on some units such as two people being offered crayons to colour, a musical film being put on in the lounge and one person had some magazines.
- Records indicated people were not supported to take part in activities that were appropriate to them. One person's individual activity record had no entries between 16 October 2022 and 29 October 2022.
- Relatives told us, "They do bingo but there is not a lot going on," and one person told us "I don't get into the garden much."
- People were supported to keep in touch with family and friends through internal visits and calls. One relative told us, "[Person's name] was feeling emotional after my visit so staff helped them call me which made [Person's name] feel better."

Improving care quality in response to complaints or concerns

● Effective systems were in place to manage complaints.

●Complaints raised had been dealt with appropriately and people and relatives were satisfied with the outcomes reached.

End of life care and support

● The service was not providing care to anyone on the end of life pathway.

● Staff were not trained in end of life care; however, provisions were available to train staff if this became a requirement in their role.

Inadequate

Is the service well-led?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Significant shortfalls were identified at this inspection. There were breaches in relation to risk management, medicines, safeguarding people from harm and abuse, staffing and mental capacity assessment principles. These issues had not been addressed through the provider's own governance systems.
- There had been a change in leadership and management of the service. The registered manager had been seconded to another service and a different registered manager was brought in for oversight during this time. This contributed to the lack of stability in the management structure within the service and led to the lack of oversight.
- Audit systems were not in place meaning the management team were not able to drive improvements in the quality of the service. For example, care plans were not checked to make sure they were appropriate. An audit checklist was completed which showed in one unit the management team had not carried out any care plans audits since April 2022, and in another unit since July 2022. One person had been at the service for over 18 months but there was no evidence their care plan had been audited.
- Management were out of touch with the service and lacked oversight. The registered manager and deputy manager did not have information or oversight on specific events which had occurred on the units, and they were misinformed on information they shared with us.
- Systems for recording were poor and not always person centred; important handwritten records were illegible and were not always person centred. Staff were using Antecedent: Behaviour: Consequence (ABC) charts for every person using the dementia assessment service. These are observational tools for recording information about particular behaviours, but the charts were not relevant to all because some people had not shown any signs of emotional distress.
- Provider oversight and monitoring was ineffective in identifying and managing risk and ensuring person-centred care.

We found systems to assess, monitor and improve the service were not sufficiently robust. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was responsive following the inspection findings and confirmed they had taken action to immediately reduce risk to people in the service and action is being taken to rectify issues identified.

Continuous learning and improving care

●The provider did not have effective systems to identify patterns and trends. For example, they did not have an overview to monitor incidents, people's weight or skin integrity. Accidents and falls audits had been completed but these were not effective. They failed to analyse trends, patterns or commonalities and provided no structure or actions to take to reduce future risks to people.

● The service was not always effective at providing oversight of actions taken in response to the feedback provided. Significant concerns were identified on the first day of inspection and we received assurances these had been addressed. However, when we checked some actions had not been completed.

We found systems to assess, monitor and improve the service were not sufficiently robust. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

●The registered manager understood the requirements of the regulations to make notifications and to comply with duty of candour responsibilities when things had gone wrong. However, we found occurrences where the registredmanager had missed opportunities to investigate and report on potential concerns.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Overall people and relatives expressed satisfaction with the care provided.

● Feedback was gained from people and relatives and actions taken where feedback suggested minor improvements could be made.

● Satisfaction questionnaires were sent out between August 2021 and November 2022. The service had and a good number of responses received from people who used the service and information collated showed a positive response overall.

Working in partnership with others

● The service worked closely with other agencies. Care records had evidence to show other professionals were involved in people's care.

● The registered manager and staff understood the importance and benefits of working alongside other professionals.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure BID and MCA were completed where restrictions were in place for people in the service. Breach of Reg 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not in place to ensure people were protected from abuse and improper treatment. Breach of Reg 13 (1) (2) (3)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were not effective at monitoring or providing oversight of the service and improving quality delivery. Risks to people were not managed, care plans did not contain all information staff needed to provide safe cares and some risk assessments were not in place where risks were identified to people (eg falls, nutrition, weight loss). Medicines were not managed safely - lack of PRN protocols, no allegry information recorded, lack of covert protocols and approvals. Staff did not have the suitable training to provide safe care and staffing levels were not sifficient to meet peoples current needs, with a high reliance on agency staff who were not inducted. This was a breach of Reg 17 (1) Good Governance.

The enforcement action we took:

WN served for Regulation 17 encompassing the breaches we found on reg 12 and 18.