Cristal Care Limited

Rother Valley View

Inspection report

44 Worksop Road
Swallownest
Sheffield
S26 4WD

Tel: 01142992369
Website: cristalcare.co.uk

Date of inspection visit:
23 March 2022
24 March 2022

Date of publication:
30 May 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

About the service
Rother Valley View is a residential care home providing the regulated activity of accommodation and personal care to up to 6 people. The service provides support to adults with a learning disability and autistic people. At the time of our inspection there were 4 people using the service. The home consisted of 6 self-contained flats in one building. People had access to a communal kitchen, dining and living room and a large enclosed garden.

People's experience of using this service and what we found
Based on our review of key questions safe, effective and well led. The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right Support
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. We made a recommendation to the provider about following best practice in line with the MCA.

The model of care and setting did not maximise people's choice, control and independence. Risks to people were not always assessed, monitored and managed safely. Systems in place did not always protect people from abuse and improper treatment. The provider had not always acted to manage infection risks. There were not always enough staff to safely meet people's needs.

People's needs were not always holistically assessed to consider what people wanted and needed. People did not always achieve good outcomes that effectively met their health, social and emotional needs. Staff did not always have the necessary skills, knowledge or experience to know how to meet people's needs. People's medicine support was managed safely.

Right Care
Care was not always person-centred or delivered in a way which promoted people's dignity, privacy and human rights. Staff did not always communicate or support people in dignified or respectful ways. Staff did not always offer people choices or involve them when supporting them with activities and meals. Recommendations and actions identified by partnership agencies regarding people's support needs had not always been promptly implemented to ensure people achieved good outcomes.

Right culture
The ethos, values, attitudes and behaviours of leaders and care staff did not ensure all people using the service could lead confident, inclusive and empowered lives. People were not being supported to regularly identify, or review, on-going individual aspirations and life goals.

Internal systems for supporting staff were not robust which led to staff feeling unconfident when supporting people in situations where people could become distressed. The was a lack of management support following incidents, to assist staff in building confidence and improving practice.

There were minimal internal quality assurance systems and processes to audit or review service performance and the safety and quality of care. Where checks and audits were carried out, they had not always identified or prevented issues occurring or continuing at the service. Where issues had been identified, the manager and provider had not always effectively overseen or ensured actions were taken to maintain or improve the quality and safety of the support being delivered at the service.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 11 August 2021).
The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We undertook a targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about safety and management and to follow up on the previous inspection. A decision was made for us to inspect and examine those risks.

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.

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 safety, safeguarding, infection control, staffing, governance and person-centred care.

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 have requested 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 remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Rother Valley View

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.

This was a targeted inspection to check whether the provider had met the requirements of the Warning Notice in relation to Regulation 17 good governance of the Health and Social Care Act 2008 (Regulated Activities)

Inspection team
The inspection was carried out by two inspectors 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.

Service and service type
Rother Valley View 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. Rother Valley View 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 service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there was a manger in post who had not been registered with us but had submitted an application to register.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used 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 used all this information to plan our inspection.

During the inspection
We spoke with one person who used the service and one relative about their experience of the care provided. We spoke with 10 members of staff including the nominated individual, quality and compliance manager, area manager, manager, and support workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We carried out observations of care to help us understand the experience of people who could not talk with us.

After the inspection
After the inspection we spoke with one relative for their view on the service provided. We reviewed records that the provider had sent to us. Due to the level of concerns we identified, we sought immediate assurances from the provider regarding actions being taken to reduce risk to people at the service.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

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

At our last inspection systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- People were not kept safe from avoidable harm because staff and managers failed to report and manage incidents safely.
- Risks in the environment were not always safely managed. One person had sustained a burn to their arm which required medical attention and dressing. Staff told us this was from the radiator in their room which was not covered. Although action had been taken to turn the radiator off, further risk had not been adequately reduced leaving the potential for further harm.
- One person had epilepsy and were regularly bathing unsupported, the risk of this had not been considered, assessed or reduced.
- The provider had failed to ensure injuries to people were investigated as a result had failed to manage people's needs safely or learn lessons. We found incidents were not recorded, several body maps had been completed showing unexplained injuries such as bruising and scratches, but they had not been reported as accidents or incidents.

We found evidence a person had been harmed due to a lack of risk management. The provider was failing to ensure they were doing all that was reasonably practicable to manage and mitigate risks. Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a continued breach of regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider took immediate action to address the safety concerns we identified. We asked them to review existing paperwork to check safety incident had been identified and strengthen the auditing of records.

Preventing and controlling infection

- At the last inspection we signposted the provider to develop their approach to managing infection control.

At this inspection, we found multiple areas of the home were unclean. We found food debris down the sides of the sofas and food spillages, bathrooms were dirty, and some bedding was soiled and needed replacing.
● We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. Despite cleaning taking place daily, people's flats were not being kept clean and hygienic. Staff told us they did not always have the time to carry out deep cleans. The provider acted on our feedback and instructed a cleaning company to carry out a deep clean of the home.
● Staff told us there were no additional cleaning staff to keep the service clean. Night staff were responsible for deep cleaning but were unable to successfully carry this out due to people's sleep being disturbed. Staff said, "People's care needs come before cleaning, so we leave the cleaning."
● The provider had systems in place to reduce infection, however they were not being followed. Therefore, we were not assured the provider was preventing visitors from catching and spreading infections. We saw staff were not following best practice when carrying out cleaning and personal tasks.
● Not all staff understood the need to check the COVID-19 test result of visitors before admitting them into the home. COVID-19 test results were not checked on the first or second day of the inspection.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm This was a breach of regulation 12 (2) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Visits arrangements were in place and people were receiving visitors.

Systems and processes to safeguard people from the risk of abuse

● People were not always safe from abuse. Systems and processes to protect people from the risk of abuse were not operating effectively. For example, when incidents of allegations of abuse were known, they had not been reported to the local authority safeguarding team or CQC.
● The provider could not be assured safeguarding systems and processes were operating safely or identifying potential allegations of abuse.
● Managers and staff had failed to consider incidents within safeguarding processes. Staff had described incidents occurring including unaccounted for bruises, and self-injurious behaviours which had not been recorded or reported this resulted in a lack of external scrutiny or investigation.
● Staff had training on how to recognise and report abuse but did not always follow the provider's safeguarding procedure
● During the inspection we made two safeguarding referrals to the local authority, which had not been previously identified or raised by the managers or staff at the service.

The provider had failed to raise safeguarding alerts regarding allegation of abuse. The provider had failed to ensure that staff safeguarding awareness ensured people were adequately protected from potential abuse. This was a breach of Regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following inspection, the provider gave assurances they would ensure allegations of abuse were reported retrospectively to the local authority safeguarding team and notified to CQC.

Staffing and recruitment

At our last inspection the provider had failed to adopt safe systems for recruiting staff. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

● Safe recruitment practices had been followed. The provider had strengthened recruitment practices. Recruitment was managed by a central team. Staff told us they did not start employment until the provider had received references and DBS assurance.
● The service currently had unfilled support staff vacancies for which recruitment was on-going. In addition, the service had been experiencing high levels of staff sickness, some of which was due to COVID-19 infections, but not exclusively.

Using medicines safely

At our last inspection the provider had failed to manage people's medicines safely. This was a breach of regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the provider was in breach of regulation 12 in other areas, enough improvement had been made at this inspection in relation to medicines management. Therefore, the medication management aspect of regulation 12 was no longer in breach.

● Practices around medicines administration were appropriate and people's medicines managed safely.
● Where medicines were prescribed 'as required' or 'as directed' there was guidance in place to ensure staff handled these consistently and safely.
● Staff were trained to give medicines and the service audited medicines to ensure they had been given as prescribed.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support;

At our last inspection the provider failed to provide person centred care and support meaning that people's needs, and preferences were not met. This placed people at risk of harm. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

● The quality of information detailed in care plans did not meet people's needs. Care plans had not been reviewed or updated in line with people's needs changing.
● Accurate records relating to health were not maintained. This meant people's health needs could be overlooked or not followed up. It was unclear what follow up action had been taken as a result of medical appointment and reviews.
● Behavioural support plans were not routinely reviewed and updated to ensure they contained the most up to date guidance, or to ensure people were supported in line with best practice. Staff told us they weren't confident to support people. One said, "I think the behavioural support plan says something about triggers, I can't remember. I think staff are following it to an extent. I think at the minute there are a lot of incidents with no apparent trigger, this has a knock on effect for other people."
● Records were not always completed to show if people had achieved their goals and aspirations. Records relating to food and fluid were inconsistent, so it was difficult to tell if people had been supported to eat and drink in line with their assessed need. One person was diabetic, and records relating to food and fluid were inconsistent and there was no evidence to show they were having regular meals, to help to maintain blood sugar levels, which were not stable.
● One person had a speech and language therapist assessment in place regarding food textures, fluid consistency and support eating meals. We observed staff not supporting the person in line with their assessed need. One person should have been supported to eat sat at a table, this was not encouraged, and the wrong sized spoon was being used to assist the person eating.

The provider failed to provide person centred care and support meaning that people's needs, and preferences were not met. This was a continued breach of Regulation 9 (1) (2) (3) of The Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience; Staff working with other agencies to provide consistent, effective, timely care

At our last inspection the provider had failed to ensure sufficient numbers of suitably qualified, competent and skilled staff were deployed to ensure safe, good quality care. This was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 18.

● We had received concerns staffing levels were not being maintained. We observed there were not always enough staff to meet people's needs.
● Staff we spoke with confirmed staffing levels were inconsistent. A staff member told us, " I don't feel the home is organised to meet the service users' needs due to staffing levels. We run on low staff and there is a lack of communication between staff."
● Despite the providers training matrix showing staff had completed mandatory and service specific training some training had been ineffective. For example, staff had received safeguarding training but had not recognised signs of abuse. The management team did not check staff's competency to ensure they understood and applied training and best practice.
● Staff told us they were not always confident to support people. One staff said, "I don't feel the training I have had is enough for me to do the job." Another staff member said, "Some people shouldn't be here at this service. We don't feel we're suitably trained to deal with behaviours. The incidents are effecting staff's wellbeing."
● Staff told us they did not receive support following incidents to assist then in reflecting on their approach. They said, "No, we don't receive any debriefs following incidents." There were no records of observation carried on how staff supported people in line with care plans.
● Professionals told us additional training in positive behaviour support had been offered but the provider had been slow to take up the offer. We discussed this with the provider who said some training had been put on hold due to COVID-19 restrictions, and they thought the training was still being followed up.

The provider failed to ensure staff have suitable skills qualifications and experience to support people safely. This was a continued breach of Regulation 18 (1)(2) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● The environment was decorated in a pleasant way.
● People's rooms had been personalised with items meaningful to them.
● There was a large enclosed garden available with a greenhouse and outside shed. The shed had previously been used as an activity room, but we found this was now locked and used as a storage area.

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).

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.

- Staff did not demonstrate best practice around assessing mental capacity, supporting decision-making and best interest decision-making. We found mental capacity assessments that had not been reviewed to ensure they were still up to date and relevant.
- The manager and staff were unclear of the contents of DoLS and if there were conditions attached to them. This was of concern as staff had informed us some people had been assessed for two to one support which, meant they required constant supervision but not always receiving this.

We recommend the provider updates their monitoring and reviewing systems for MCA to ensure they are following best practice.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection in August 2021 we found evidence to support a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was failing to operate effective systems and processes to assess and monitor the service, we issued a Warning Notice for this breach.

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

Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The service is currently without a registered manager and the area manager who is new in post is acting as service interim manager for the home, until a new registered manager can be recruited.
- At this inspection, not enough improvement had been made or sustained and the service remained in breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17. The continued breaches and deterioration of quality and safety had left people exposed to potentially high risks of harm and poor-quality support and evidences a lack of continual improving care.
- There were some internal quality assurance systems and processes to audit or review service performance and the safety and quality of care, but these were ineffective. Where checks and audits were carried out, they had not always identified or prevented issues occurring or continuing at the service. For example, infection control and health and safety audits had not identified issues we found during this inspection. Where issues had been identified, the manager had not always effectively overseen or ensured actions were taken to maintain or improve the quality and safety of the support being delivered at the service. For example, the manager was aware of a health and safety issue and failed to ensure future risks were mitigated.
- Internal systems of staff and management appraisals and supervisions were not operating to help staff to understand and fulfil their responsibilities and support staff to be positively accountable for their performance. Staff told us their performance was not managed well and they were not always confident and capable of supporting people who could be distressed. Several staff said they did not feel they were able to fulfil all their duties to a good or safe standard.

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; Working in partnership with others

- Recommendations and actions identified by partnership agencies regarding people's support needs had not always been implemented or consistently followed to ensure people achieved good outcomes.

● Health and social care professionals told us about several examples where staff had not acted to follow advice and directions in care plans they had developed alongside staff, resulting in avoidable situations where people were to move out of the service as staff could not meet their needs or keep them safe.
● Safety incidents relating to neglect, and unsafe care were identified at the inspection. These incidents had not always been reported internally or to external agencies openly and in a transparent way, or at all to ensure there was an adequately informed review, investigation and actions agreed to help avoid or prevent these issues happening again. Staff and management could not explain the reasons for this.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● People did not always have an accurate and contemporaneous record of their care in place. People's care plans, risk assessments and monitoring records in relation to food, behaviour, and social support needs were not always accurate, complete or up to date.
● There had been some improvements made to some aspects of the service such as medication, recruitment and compliance in training. However, other areas had not improved, and further and ongoing concerns were identified, as documented throughout the report.

The provider failed to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained and failed to report in line with legal requirements. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Following the inspection, we met with the provider to discuss and emphasise the significant concerns we had identified on our inspection. They told us they were committed to improving the service and submitted an action plan on how they would address the concerns and would monitor the service to ensure it was operating to a better standard.