

RV Care Homes Limited

The Moat House

Inspection report

Great Easton
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Date of inspection visit:
15 October 2019
16 October 2019

Date of publication:
29 November 2019

Ratings

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| 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

The Moat House is a residential and nursing home registered to provide accommodation for up to 72 people in one adapted building, comprising of five suites known as Willow, Oak, Aspen, Maple and Thistle. People residing in Willow require support to manage their dementia and nursing needs. Oak provides nursing care. Aspen accommodates people living with dementia. Maple is the residential unit and Thistle is currently closed. At the time of our inspection, there were 41 people using the service.

People's experience of using this service and what we found

Changes within the provider's management team, and frequent changes of manager at The Moat House have led to a lack of leadership, management and oversight of the service. This, combined with high use of agency staff, has impacted on the quality of the service provided and has resulted in a failure to identify, assess and manage risks to the health, safety and welfare of people using the service.

At this inspection there was no registered manager in post. The last of a succession of registered managers cancelled their registration with us, the Commission on 10 September 2019. Since that date, there have been two interim managers, one being the providers area quality director. A new manager has been appointed and due to commence employment at the end of October 2019. People, their relatives and staff told us this has impacted on the culture in the service and the quality of the care people have received. Staff did not feel valued and did not have a clear understanding of what was expected of them.

The providers governance framework and home improvement plan had identified where improvements were needed, but the lack of management oversight has failed to drive the required improvements. Safety concerns and risks to people, such as security of the premises, unidentified bruising and choking were not consistently identified or addressed quickly enough to keep people safe. People were at risk of harm because staff did not order, store and administer medicines safely, or follow current national guidance and standards in relation to infection control.

Safeguarding policies and procedures were not fully imbedded into practice. Staff were not clear of safeguarding and whistle blowing process, when and how to raise concerns and are wary of doing so, which meant there were times when people's safety had not been protected.

The workforce in the service has been made up almost entirely of agency staff. Whilst some agency staff had worked at the service on a consistent basis, a high proportion had not. This inconsistency in staff who are unfamiliar with people's needs had placed people at risk of harm. Staff recruitment checks, including agency needed to improve to ensure employees were safe to work with people using the service.

Staff had received training to give them the skills, knowledge and experience to carry out their roles, however not all training was up to date. People who ate little and often were not routinely offered snacks or being prompted to eat and drink. There were no visual aids, to help people living with dementia to choose

and remember what they had ordered for their meals.

The facilities and premises were not designed to enhance the wellbeing of people living with dementia. The environment needed maintenance throughout, carpets were stained, and doors and woodwork were chipped.

Staff interactions were kind and caring. However, people were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Care plans were not always up to date where changes in people's care, support and treatment had been made. Where people had known behavioural issues, there was minimal guidance for staff on how to support them at times of agitation and distress. The requirements of the Accessible Information Standards were not being met. There was minimal information available to support the communication needs of people with a disability or sensory loss.

Incidents where people had complained about staff actions or been party to verbal aggression by staff have not been addressed in a timely manner. There was little recognition for people wishes and preferred priorities at the end of their life. No end of life care plans was in place to guide staff on how to provide care to a person who was at the end stages of their life.

Rating at last inspection and update

The last rating for this service was requires improvement (published 10 January 2019) and there was a breach of regulation, good governance. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, enough improvement had not been made and the provider was still in breach of the regulations.

The service is rated inadequate. At the last two consecutive inspections, this service has been rated requires improvement.

Why we inspected

The inspection was prompted in part due to concerns received about a lack of safeguards being raised by the service in relation to falls, unexplained bruising, weight loss, poor recording and high use of agency staff. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report. For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The provider sent us an updated service improvement plan on 30 October 2019 outlining how they intend to address the concerns we have raised at this inspection. Immediate action had been taken to make the premises safe and protect people at risk of choking.

Enforcement

We have identified breaches in relation to safe care and treatment, safeguarding people from abuse and improper treatment, meeting people's nutritional needs and good governance.

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

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements. If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate ●

Is the service effective?

The service was not always 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 ●

The Moat House

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team

The team consisted of two inspectors, two assistant inspectors and a specialist advisor who was a nurse, 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

The Moat House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with 12 people who used the service, six relatives and one GP who regularly visits the service about their experience of the care provided. We spoke with representatives of the provider, which included the assistant director and the area quality director. We also spoke with an interim manager, deputy and

clinical managers, as well as six agency staff, 13 permanent staff including seniors, care assistants, an activities coordinator and the chef. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included 18 people's care records and multiple medication records. We looked at five staff files and agency records in relation to recruitment and staff supervision and a variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Safeguarding policies and procedures were not fully imbedded in the service. Staff were aware of safeguarding procedures but had not recognised or responded to incidents such as unexplained bruising, verbal and physical abuse and medicines errors. As a result, potential abuse, or inappropriate care had gone undetected and people had been exposed to a significant risk of harm occurring.
- Staff were not clear of the whistle blowing process, when and how to raise concerns and were wary of doing so.
- Where people had been identified as having behaviour that was challenging, known triggers were poorly recorded. Failure to have adequate information to guide staff on how to support people to reduce the cause of their distress and manage their behaviour had placed, and continued to place, individuals and others at risk of harm.

Systems and processes in place to safeguard people from the risk of abuse and improper treatment were not effective. This is breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks to people's safety were not consistently identified or addressed quickly enough. Our previous inspection in November 2018 found an internal lift linked The Moat House and a separate dwelling. We found members of the public were able to access The Moat House via this lift. Despite assurances, we found at this inspection no action had been taken to prevent access to the premises. An incident report identified a member of the public was found in the service in June 2019 and had to be escorted off the premises.
- Risks were not well managed to ensure people's safety. Information about risks in people's care records were incomplete or inconsistent. For example, where a person had been prescribed oxygen their 'Oxygen Therapy Assessment' was blank, with a 'post it' note on the front stating 'Awaiting info from GP'. The failure to provide staff with all the information they needed to understand how to support this person to safely manage their oxygen, placed them, other people using the service, staff and visitors at risk of harm.
- Inconsistency of care records and high use of agency staff had placed people at significant risk of harm. For example, records showed agency staff had given two people sandwiches and toast to eat, where they had been assessed as a high risk of choking, requiring their food pureed.

Using medicines safely

- A review of people's medicines and associated Medication Administration Records (MAR) across the service

identified staff had not ordered, stored and administered people's medicines safely. One person told us, "An agency member of staff missed my medicines last weekend. Additionally, one night I had to buzz at 10.30pm as I had not had my medicine. The staff that came told me I should be taking 12 tablets, but I know I only take 10. I take two co-codamol before breakfast, two in the morning, two at lunchtime, two at 6pm and two at night. I had to insist I was not taking more."

- People's medicines records were not always up to date or completed accurately. Medicine records contained omissions and errors, which had not been identified in monthly medicine audits, or investigated to identify what went wrong.
- Medicine competency assessments were not robust and failed to identify where staff were not competent to safely administer medicines. For example, one member of staff had been assessed as competent, but they were unable to explain processes for ordering, storing and administering medicines or the procedures for covert medicines.

Preventing and controlling infection

- Staff were not always following current national guidance and standards in relation to infection control. For example, we observed an agency member of staff carrying bags containing soiled items, such as pads and used gloves and aprons to the sluice room, not wearing gloves. They failed to wash their hands after disposing of the bag.
- Areas of the service were not clean, these included dirty or stained toilet rims, build-up of lime scale in toilets and dirty plug holes in showers.

Learning lessons when things go wrong

- Although issues about risks to people's safety had been identified in the home improvement plan during the inspection, we continued to find incidents of unexplained bruising, and medicines errors that had not been identified and acted on.
- The incident and accident folder contained four incident forms relating to medicine errors, where people had been exposed to a serious risk of harm. No investigations had been undertaken by a competent person within the service to establish the cause of these errors, prevent further occurrences and make sure improvements were made as a result.

Due to poor governance and the lack of managerial oversight of the service people were placed at risk of harm. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- People, and their relatives had mixed views about staffing. One person told us, "Sometimes there is not enough staff, sometimes there is only one to help me, when there should be two." Other comments included, "I use the buzzer (call bell), they are quick," and "They come quickly, no problems, I know if I press my buzzer someone will come." One person's relative told us, "I think they are lacking in permanent staff, my [Person] is better with those they know, they can be difficult with agency staff who don't know them."
- Staff were mixed in their views about the use of agency staff and the impact this had on the service. Comments included, "Communication between agency and permanent staff can be terrible," and "We have very few permanent staff and high numbers of agency who don't work on a regular basis. It's ten times easier when we have regular permanent staff who know people's needs. More positive comments included, "Don't get me wrong, some of the agency staff are great. Some have been here longer than me and are good to work with. But it just flows better with permanent staff," and "I think the service does try to use consistent agency staff. The agency staff are very good, they are helpful and supportive, they work very hard."
- The area quality director told us, between 60-70% of care and nursing staff were agency. Whilst some agency staff had worked at the service on a consistent basis, a high proportion had not. This inconsistency

of staff, unfamiliar with people's needs, had placed people at risk of harm.

The high numbers of agency staff deployed who were unfamiliar with people's needs has led to unsafe care, including significant medicines errors and placed people at risk of harm. This is a breach of regulation 18 Health and Social Care (Regulated Activities) Regulations 2014

- The employee list showed 26 staff had left employment in the last 12 months. The area quality director told us recruitment had been difficult due to the location of the service, however a member of staff had been appointed, based in the region, to focus on recruiting new staff. At the time of the inspection three new staff had been recruited.
- The lack of provider and managerial oversight had led to poor recruitment practices, including oversight of agency staff. 24 out of 49 agency staff had no profiles in place detailing their Disclosure and Barring Service (DBS) checks, and their right to remain and work in the UK. Agency nurses did not have an up to date pin number to confirm revalidation with National Midwifery Council (NMC) and their fitness to practice.

The lack of provider and managerial oversight has failed to ensure staff, including agency staff are of good character and safe to work with vulnerable people using the service. This is a breach of regulation 19 Health and Social Care (Regulated Activities) Regulations 2014

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- The assessment process had not been carried out robustly when people first started using the service, and therefore elements of their care needs were missed, or had the potential to be missed. For example, an audit of a person who had moved to the service in October 2019 had no admission assessment or moving and handling plan in place. This failure to ensure vital information was completed in a timely manner placed the person at risk of harm, as staff did not have access to all the information they needed to provide safe, care and treatment.
- People's care plans did not contain relevant information about specific health conditions, such as Parkinson's, skin disorders, asthma or the use of oxygen and therefore staff could not be assured they were providing care and support in line with current guidance, and best practice.

The failure to have effective systems in place to properly assess people's needs, placed them at risk of receiving inappropriate care and treatment. This is breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

- People's feedback about the food and mealtimes was positive. Comments included, "Very nice, I enjoyed it, alright", "I am a poor eater, but it was tasty," and, "Most of the food is good, I eat most of it. I have always got drinks, if I want snacks I have got my biscuits. Sometimes they will bring me something different from the kitchen. They bring grapes, red and black currants, certainly get plenty of vegetables."
- Food looked appealing and appetising, except for pureed diets. A relative commented, "[Person] has only recently gone onto a soft diet, it looks okay for a pureed meal, but maybe could be a bit more variety." We saw the tea time meal was sandwiches and soup on both days of the inspection. There was minimal choice for people who needed a pureed diet, with only soup and mash offered.
- Where people's diets were being monitored for health or weight loss, we found recording on charts was variable and did not provide an accurate picture of what the individual had eaten or drunk each day. Fluid intake was not being tallied to ensure people were keeping hydrated.
- Poor recording on the food and fluid charts meant we were unable to ascertain if staff were following guidance from professionals, such as the dietician to provide people with high calorie snacks, and fortified milk shakes.
- Where people ate small amounts, or refused food, there was no information about what else, including

snacks was being offered. Charts showed no food was offered past 5pm, however the staff and the chef told us this was not the case. The chef told us, "A lot of food goes up onto the units in evenings for tea, including fresh sandwiches, custard pots, cheese and biscuits, cereals, milk, cakes, crisps, chocolate, fresh fruit and chocolate drinks, but they [chef] told us, these were not always touched."

Due to lack of governance and high use of agency staff people were not receiving adequate nutrition and hydration. This is breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 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 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Where people did not have the mental capacity to make decisions, we saw best interest decisions had been made with the appropriate people in relation to medicines, thickened fluids and pureed foods and DNACPR. (This is a decision made in advance that attempted Cardiopulmonary Resuscitation (CPR) would not be likely to be appropriate for a person in the event of cardiac arrest.)
- Staff had not always fully understood the requirements about people consenting to care, support and where required treatment. For example, a member of staff had locked a person in their room at night, which they believed had been for the person's safety. Despite failing health, this person had capacity and was not consulted regarding these actions. The bank member of staff had not recognised this was depriving a person of their liberty and a form of restraint, or that their actions were a disproportionate response to the risk of harm posed to the person.
- Staff (bank and agency) had not recognised how their actions, when providing support to people was a form of 'restraint'. For example, an agency member of staff had wedged a table and their knee in front of the person at risk of falls to prevent them standing. The agency staff had not understood their actions were inappropriate, and against the person's human rights.
- Further learning was needed to ensure staff were consistently applying the requirements of the MCA and DoLS legislation. The training programme showed the service employed a total of 50 staff, with only 60% who had completed this training.

Staff lacked understanding about control, restraint and restrictive practices which placed people at risk of harm. This is breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- New staff told us they completed an induction when they joined the service before commencing shifts as a permanent member of staff. This included shadowing experienced members of staff. However, we found only two of the 24 agency staff had had an induction, when they first attended the service.
- Staff told us they had good access to training to ensure they had the skills and knowledge to carry out their

roles and meet people's needs. Comments included, "I did a nine-week course as a nursing assistant. I have also completed Boots pharmacy training, insulin and catheter training. The training is really good, they give you real life scenarios," and "My training is up to date, apart from moving and handing and basic life support, which I need to do face to face."

- The training programme reflected mandatory training was provided via a mixture of e-Learning and face to face, however not all training was up to date. For example, staff had not received training in how to support people in distress, or how to divert incidents of aggressive behaviour, including appropriateness of using restrictive practices.
- Staff told us they had received training to ensure they had the skills and experience to support people with specific health conditions, such as managing people's hydration and nutritional needs via PEG. Percutaneous Endoscopic Gastrostomy (PEG) is medical procedure where a tube is passed into a person's stomach to provide a means of feeding when oral intake is not adequate, due to the risks of choking, because of poor swallowing.

Staff working with other agencies to provide consistent, effective, timely care

- People, their relatives and information in care plans reflected people had access to the healthcare they needed, however outcomes of professional visits were not always updated or properly recorded.
- Relatives told us there was often miscommunication between them, the service and the GP in relation to diagnosis of conditions and their ongoing health. However, a GP visiting the service commented, "I think the staff are very good, they are mostly regular staff and they call me nice and early when they have a concern. Communication between us and the service is very good. When I hand them a prescription, they go and get it fulfilled the same day and I don't have any concerns, they listen to what advice I give them."
- Where further information or health professional input was required, this had not always been followed up. For example, a referral to the falls team had not been followed up for a person assessed as high risk of further falls. Neither had a referral been made to the Speech and Language Therapist (SaLT) following a review of a person's choking risk assessment which should have triggered an immediate referral.

Adapting service, design, decoration to meet people's needs

- At our previous inspection in November 2018 we were told an initiative referred to as the 'Harmony Program' was being introduced to make the service as 'conducive as possible to people with dementia to enable them to meet their full potential and create a 'home from home'. We did not see evidence that these improvements had been made at this inspection.
- The facilities and premises are not designed to enhance the wellbeing of people living with dementia. We found little evidence of dementia friendly items for people to hold and touch.
- The environment needed maintenance throughout, carpets were stained, and doors and woodwork were chipped.

Supporting people to live healthier lives, access healthcare services and support

- Relatives had mixed views about being kept informed about the health and welfare of their family members. One relative told us, "I am concerned about the high use of agency, who do not know people's needs, they do not always recognise signs that my [Person] is unwell. For example, if [Person] has a urinary infection, they present differently, they get muddled, and if agency do not know them, they think this is normal and potential infections go unnoticed. This does not make me feel confident the service is on top of people's health." Other comments included, "They keep us informed, no problems there," and "Staff have noticed my [Person's] weight had gone down, they are completely on top of that."
- People told us they had access to their GP, and other healthcare services. One person told us, "I have improved since I got here, I had lots of pain patches but only got one now, the GP is talking about reducing it more. I go to the dentist, went a month ago and the chiropodist comes in, I am doing pretty well on the whole." Another person commented, "Staff are good, they know when I am not well, they say that I don't

chat."

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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

- Although we observed staff were kind and caring, people told us they did not always listen which made them feel like they didn't matter. One person told us, "Staff don't always bring the right cutlery, my right arm does not work properly so I need a spoon. Some staff are alright, but they are buzzing about and get frustrated, when I ask, there is not enough time. I say I am invisible, why do they forget me."
- We saw some positive interactions between people and staff, however staff were focussed on the delivery of care and did not always have time to sit and talk with people for a meaningful length of time.
- People told us staff did not always have the time to carry out tasks or remember how they preferred their needs met, which left them feeling agitated. One person told us, "I cannot bear cold water on my teeth, so I ask staff to bring me boiling water, I have to chase and chase this."
- People's relatives and staff told us the high use of agency staff had impacted on the quality of the care people received.
- Staff told us people were generally calmer when supported by regular staff, as they recognise them and feel more reassured. One member of staff told us, "[Person] is absolutely fine when I take their blood sugar and administer their insulin, but they scream the home down if it's an agency." Another commented, "Peoples don't like changing faces, and families prefer to speak with staff who know their family members." A relative confirmed this stating, "[Staff name] is a permanent staff member and they are excellent, very focussed and knows my [Person] really well, they are always friendly and happy."

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

- People told us they were not always involved in making decisions about their care or kept up to date when things changed. One person told us, "The staff come and check on me in the night, they say they have to come every two hours, it used to be four hours, they have not said why it has been changed, perhaps I am getting worse."
- People were not involved in weekly or monthly menu planning. They were asked to make a choice from two options the day before for their midday meal. This is an issue for people living with dementia, or short-term memory loss, who told us they could not remember what they had chosen. Comments included, "Food is okay, but I can't remember what I am having," and "Food is very nice, I can choose, we have two choices, but I have forgotten what I am having today."
- No visual prompts, such as pictures or photographs were available to assist people to make choices or remember what they had ordered.

Respecting and promoting people's privacy, dignity and independence

- People and their relatives told us staff were respectful of people's privacy and dignity. Comments included, "Staff say what they are going to do, they close my curtains before helping me with my personal care," and "There's lots of people walking around but I like my privacy and prefer to have my bedroom door closed. My room is lovely, these are my cabinets and my pictures. I mostly sit here, in my room."
- One relative told us, "It is okay, the care here is okay on the whole, my [Person] is well presented and settled. Staff are pretty nice, pretty caring, I think they treat [Person] with respect."

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

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

- The reliance on agency staff to fill staff vacancies and deliver care across the service resulted in people's needs not being consistently met.
- People told us agency staff did not always understand or know how to support them. One person told us, "You would think that they would put a new person on with an experienced member of staff, quite often it is two new agency staff and I have to write down to tell them what to do."
- Care plans were not always up to date where changes in people's care had been made. Failure to have up to date and accurate information had placed people at risk of receiving poor and inappropriate care.
- Staff, including agency staff, told us they did not have time to read people's care plans but looked at the 'Pen Profiles' at the front of the plans. However, we found these were not always up to date or reflective of people's current needs.
- Where people could get upset and their behaviour challenging, there was minimal information on how to support them at times of agitation and distress. The behaviour of one person placed two others at risk of coming to harm, as they were both on textured diets due to a high risk of choking. Neither persons care plan referred to the risk from this person feeding them toast and biscuits, or guided staff on the actions they should take to minimise the risk of harm.
- Antecedent Behaviour Charts (ABC) used to record incidents of distressed behaviour were not being used effectively. Incidents were recorded that were not behavioural issues. Additionally, these were used routinely with no oversight or analysis to evaluate the information, to look at emerging themes or patterns that may cause the person's behaviour to change.

End of life care and support

- People's care plans had limited information about their wishes and preferred priorities, such as the spiritual and cultural needs at the end of their life. Without this information, staff would be unable to ensure people's wishes at the end of their life were respected.
- The provider had produced a seven-day plan to assess and monitor people's care, treatment and wellbeing at the end stages of their life, however these were not being used. For example, we were told one person was coming to the end of their life, but there was no end of life care plan in place to demonstrate the level of care being provided

The failure to have effective systems in place to properly assess people's needs, placed them at risk of receiving inappropriate care and treatment. This is breach of regulation 9 of the Health and Social Care Act

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The requirements of the Accessible Information Standards were not being met. There was minimal information available to support the communication needs of people with a disability or sensory loss.

Improving care quality in response to complaints or concerns

- People, and their relatives told us complaints had not been consistently investigated and responded to in a timely manner, by the previous registered manager. One person told us they had raised a complaint about a member of staff in the summer because of the way they had treated them. They commented, "Although I love it here, I told my [relative] I wanted to move, as I have never been treated like that before." They told us their complaint had not been responded to and the member of staff had remained in post, which was difficult as they had to face them when they were on shift. We addressed this with the area quality director who took immediate action to ensure the member of staff did not return to the service and provided an apology to the person.
- A relative told us they had also complained about this same member of staff to the last registered manager about a medicines concern. They told us initially their concerns had not been investigated, then when an investigation was carried out, the member of staff was not suspended, and remained in post, which made it difficult for them to visit their relative. The area quality director had followed up on the relative's complaint and met with them to discuss the issues and provided a formal apology.
- We reviewed the complaints folder which showed, since the area quality director had been managing the service, they had acted on complaints, responded in a timely manner and sent a letter of apology.

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

- The service employed two permanent activity coordinators. Both were enthusiastic about their roles, and we observed them facilitating group activities and spending time with people in their rooms. One person told us, "We are practicing singing and we are going to do a concert at Christmas, 12 of us sing, I love singing."
- The activities staff had empowered people to maintain and make new links with community, including designing an edible sensory garden. People had chosen the herbs themselves from a local nursery and the local Horticultural Society had visited the service to talk with people about the garden.
- One person told us, "I started a garden club as I felt people needed to do more. I have just been given an award and a voucher. I have started planters' boxes for the patio, which I am going to grow hyacinths in and then everyone will have one in their rooms."
- People were supported to maintain relationships with people that mattered to them including family, and friends. One person told us, "We have WiFi here, and I have got my own computer so that I can write to my friends."
- People's differences, lifestyle choices and identity, such as age, ethnicity and sexuality had been identified in their care records and provided guidance to staff on how these were to be met.

People told us they were supported to maintain their identity, including their religious beliefs. Comments included, "We have a monthly church service. I made a church window from material with lights behind. When we have the service, we hang them up so people with dementia recognise that we are in a church," and "Tomorrow we are going to Broxted Church, to share the Christmas cards we have made."

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- At this inspection there was no registered manager in post. The previous registered manager left employment at The Moat House on 27 June 2019. A new manager commenced and was registered with the Commission on 29 August 2019, however they cancelled their registration with us on 10 September 2019. Since that date there have been two interim managers. A new manager has been employed, but we have not yet received an application.

- The frequent changes of manager at The Moat House has led to a lack of leadership, management and oversight of the service.

- People, their relatives and staff told us the constant change of managers and high agency use has had a detrimental impact on the culture in the service and the quality of the care people have received. One person told us, "It is reasonably run, had a period when everyone was leaving, they have got a new manager but not met them yet." A relative commented, "There is no permanent manager overseeing things."

- Staff comments included:

"When there's continuity it is good here, but I think you have to have a very strong character to get passed the constant changes and carry on doing your job. Staff morale is low, I don't feel supported or valued by the management team, or the organisation, I feel they have lost direction."

"I have seen several managers come and go, with different styles of management. I feel supported by the deputy and clinical manager, they have sustained the service."

"We have had so many different managers, it has been rocky, the atmosphere wasn't very good, wasn't comfortable, we have had no proper guidance, we didn't know what we were doing. The area quality director has very strong leadership, compared to others, however, we have just found out we are having another manager, we were just getting on our feet again. We knew there was going to be a new manager but didn't know it was going to be so quick, staff morale was starting to get better, it's another big change."

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

- The lack of continuous leadership has resulted in no structure or direction for the staff team. They were unclear on their roles and responsibilities. One member of staff told us, "Managers come in and they try and fix things that aren't broken, which ends up breaking them. It's like they try to assert their authority by changing the way we do things just for the sake of it. Then when that manager leaves it's us the staff that are

left trying to fix things. It's why all the staff have left, they can't cope. It's also the way the new managers deal with the changes. Staff don't feel listened to."

- Staff did not have regular support and guidance to enable them to effectively carry out their roles, which meant they were not recognising or managing risks.
- The providers governance framework 'Cornerstone' had identified where improvements were needed, however due to inconsistency in management, the required improvements had not been made.
- Governance systems implemented, such as the daily, night and weekend 'walk arounds' on each unit, were not effective. They did not feed into the daily flash meetings to ensure issues identified were addressed and managed appropriately.
- Clinical review meetings held monthly from 12 March 2019 to 31 July 2019 identified the same issues, including medicines management. Where actions had been identified, and these had not worked there had been no lessons learned, or alternative actions sought from other agencies, to drive improvement.

Due to poor governance and lack of managerial oversight of the service people were placed at risk of harm. This is a continued breach of regulation 17 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 provider had not acted on their duty of candour in relation to safeguarding people from harm and learning lessons when things went wrong.
- The area quality director had responded to more recent complaints and had seen these as an opportunity to engage with people and their relatives to make improvements to the service. One relative told us following a meeting to discuss a complaint they had raised; the area quality director had asked them to become a 'family representative.' This involved liaising with other relatives and meeting on a regular basis with the manager to share general concerns such as staffing levels and agency use. They commented, "They are listening, and they are doing the right thing, and I believe they are turning a corner."

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

- Staff told us they did not feel valued and did not have a clear understanding of what is expected of them. Comments included, "With every new manager, they make changes, one day we are doing things right, then the next day we have a new manager and we have to make changes," and "We have lots of agency, and need more permanent staff and management to improve, it is disheartening, it's a ship without a captain."
- Staff told us their views were not always listened to. One member of staff told us they had been asking for the last four to five years, to have better décor, lighting and sensory equipment to meet the needs of people with sensory impairments and those living with dementia. They told us they had previously written a report identifying ways that could improve the environment to make the service more dementia friendly, "but nothing happened."

Continuous learning and improving care

- The lack of oversight has led to safeguarding concerns or complaints not being identified and addressed in a timely way.
- There was no formal system or process in place that ensured incidents were reviewed and monitored to make sure action was taken to remedy the situation, protect people, prevent further occurrences and make sure improvements were made as a result.
- In the last year, 26 staff had left the service, resulting in high levels of agency staff being used. Although efforts had been made to ensure the same agency staff were used to provide continuity, the level of demand to safely staff the service meant using agency staff who do not know people's needs which had led to

incidents of poor care and placed people at risk of harm.

Working in partnership with others

- There was limited engagement with other organisations, agencies or networks to share best practice, expertise or resources to improve the service and deliver a good experience of care for people.
- Where safeguarding incidents had occurred, these had not been raised to the appropriate authorities, such as the Local Authority (LA) safeguarding team or the Commission in accordance with current legislation and regulations. The LA and the Commission have had to prompt safeguards to be raised following their visits to the service.