Leong E N T Limited

Ralphland Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Ralphland is a residential care home providing accommodation and personal care to older people, some of whom are living with dementia. The service can support up to 39 people. At the time of this inspection there were 34 people living at the service, which is provided over three floors in one adapted building

People's experience of using this service and what we found
There were significant and widespread shortfalls in the governance of the service. The provider and managers had failed to identify issues we found including with health and safety and record keeping, including risk assessments. The leadership was weak, inconsistent and overbearing. Systems were ineffective in driving improvements and high quality care. The provider had failed to act on concerns identified during our inspection. This left people at risk of harm.

People were at risk of avoidable harm because risks were not recorded accurately, monitored or managed. We raised a safeguarding concern for one person who was at risk of choking, as we could not be sure this had been managed appropriately.

Health and safety was not well managed. This put people at risk of potential harm. We contacted the fire service, who attended the home and introduced measures to reduce the risk of harm to people in a fire situation. These were implemented with immediate effect. No control measures had been introduced following positive samples of legionella being found in the service.

Good outcomes were not always achieved for people living at the service. People were at significant risk of dehydration due to their low fluid intake. The environment was not suitable for the needs of people living there. Access to communal areas was limited.

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.

Staff did not always understand people's care needs. They had not received sufficient training or support to equip them for their roles and responsibilities.

Care was provided in task-centred, institutionalised ways. Little consideration was given to people's wellbeing or emotional needs. People were not always treated with dignity and respect; they were not able to have privacy in their bedrooms. People's independence was not promoted.

People did not receive responsive care. When assistance was requested there were delays in this being provided, which caused people discomfort. People were socially isolated, with no access to the wider community.

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

Rating at last inspection
The last rating for this service was good (published 10 February 2017).

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified multiple breaches in relation to safe care and treatment, fit and proper persons employed, person-centred care, staffing, dignity and privacy, premises and equipment, need for consent and good governance.

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 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.

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.	**Inadequate**
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**

Ralphland Care Home

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
Three inspectors carried out the inspection; two inspectors visited the service on each day of inspection.

Service and service type
Ralphland Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with CQC. A new manager had been in post since September 2019. They had submitted an application to CQC to become the registered manager. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of care provided.

Notice of inspection
This inspection was unannounced on day one. We told the provider we would be visiting on day two. The inspection was unannounced on day three.

What we did before the inspection
We reviewed information we had received about the service, including notifications for events the provider is required to tell us about. We sought feedback from the local authority and commissioners 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 seven people who use the service and four relatives about their experience of the care provided. We spoke with nine members of staff including the head of operations and their personal assistant, manager, deputy manager, three care staff and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider

We reviewed a range of records. This included ten people's care records and multiple medicine records. We looked at three staff recruitment and supervision files. We reviewed a range of records relating to the management of the service, including health and safety records, staff meeting minutes and policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and policies and procedures. We spoke with two professionals who regularly visit 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 the last inspection this key question was rated as good. 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; Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People were not protected from the risk of abuse and avoidable harm. The provider's oversight of the service had not always kept people safe or reduced risks.
- Risks including pressure sores, choking and falls were not always documented, accurate or completed to ensure staff had adequate information to mitigate risk. Managers and staff could not always demonstrate the measures they had taken to prevent risks. For example, monitoring people in bed, continence management and food and fluid intake. It was not clear a specialist diet recommended for one person was being followed. We raised a safeguarding concern due to the risk to this person.
- Fire safety was not well managed. Some escape routes were blocked with furniture, trolleys and bins. The provider knew about staff fire training issues, which they had failed to address.
- The fire risk assessment had not been reviewed following changes or fires. We reported our concerns to the local fire and rescue service. A senior manager from the fire and rescue service visited on the second day of the inspection. As a result, the provider confirmed they had increased night staffing and had taken two bedrooms out of use with immediate effect. The provider assured us a new fire risk assessment would be undertaken by a competent person.
- Guidance from environmental health had not consistently been observed following positive samples of legionella being identified. The system had been disinfected. However, control measures had not been implemented to reduce future risk.
- No electrical wiring certificate was available to demonstrate electrical installation at the home was safe.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- Safe staffing levels were not always maintained.
- Dependency levels were not accurately recorded or used to determine safe staffing levels. At night between 9pm and 5:45am two care staff were available. Ten people required two staff to assist them with their personal care needs, leaving other people unsupervised when staff were busy elsewhere.
- Staff routines were task based and institutionalised; staff intervention was mainly provided at mealtimes or when people required personal care.
- Staff confirmed they did not have time to spend with people. Family stayed with one person to assist them to use the toilet because staff said they did not have time to take them to the toilet.
- Some staff worked 15 hour shifts. There were high levels of staff dismissals and sickness. Staff were tearful

on occasion and told us morale was extremely low because of work pressures and lack of support.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safe recruitment processes were not followed to ensure staff had the knowledge, skills and experience needed to provide safe care.

This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Infection control procedures and audits required improvement to ensure people were protected from the risk of infection.
● The service used a wide range of cleaning materials. Risk assessments had not been produced for staff to follow when using these.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● A new medicines system was in development.
● Protocols were not in place to identify when people may need 'as and when required' medicines. Topical medicine records were not in place. The deputy manager showed us documentation, but this was not yet in use.
● The medicines audit policy was not sufficiently detailed to support the safe use of medicines. There were no details of what checks would be completed and the frequency of these.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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
- People's care and support did not consistently achieve good outcomes. Despite assurances from the provider to review all care plans there was insufficient evidence to confirm they had taken action to reduce risks to people.
- People did not receive an assessment by the manager or a delegated member of staff in line with the provider's policy to ensure their needs were understood and could be met.
- Staff did not always understand people's care needs. Care plans did not contain adequate information or guidance to support them with delivering effective care. One person had been admitted to the service on an emergency basis. We observed the person remained in their bed in a darkened room, receiving little staff supervision or attention. We raised a safeguarding concern with the local authority.
- People stayed in bed or remained in their chairs for long periods of time with limited or no stimulation.

This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act (Regulated Activities) Regulation 2014.

Supporting people to eat and drink enough to maintain a balanced diet
- People were at significant risk of dehydration. The systems in place were ineffective in monitoring people's food and fluid intake.
- People did not receive support with their eating and drinking with reference to best practice.
- Fluid charts did not identify what people's target fluid intake should be each day and what action should be taken if they did not have this. We found examples of people's fluid intake being as low as 150ml in a day, or one occasion 80ml, less than one glass of water. The provider told us they would complete a formal investigation into this. We found no evidence that an investigation had been completed.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Dementia friendly practices around mealtimes were not followed. People did not know what food they were being served.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
- People did not always receive effective, coordinated care.

● Information about people's health needs was not detailed in their care records.
● It was not clear if and how information was communicated with healthcare professionals in a timely way. Staff were not always aware of which healthcare professionals were working with people and did not follow up the outcome of visits to consider if any recommendations had been made.
● Handover records were brief and did not take into account people's immediate or changing needs.

Staff support: induction, training, skills and experience
● Staff training was not monitored effectively. It was not clear when staff had completed their training or when this needed refreshing to update their knowledge.
● Staff had not always received suitable training in relation to people's specific health needs and associated risks. This left people at risk of receiving ineffective or unsafe care.
● Staff were offered promotions within the service without further application or interview to test their knowledge and experience, and to ascertain if they required any additional support. This meant people could not be confident the recruitment process was fair and did not disadvantage staff with protected characteristics.
● There was a lack of support from the provider for the management team to enable them to carry out their duties effectively. They did not always have up to date knowledge and skills to support the staff team, including training in completing assessments and care planning.
● Supervisions and training records did not evidence a robust approach to monitoring and supporting staff wellbeing and continued development.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act (Regulated Activities) Regulation 2014.

Adapting service, design, decoration to meet people's needs
● The environment was not conducive to meeting the needs of people with dementia. People were not able to navigate their way around the service. The dining room was locked outside of mealtimes to prevent people accessing this space due to commercial equipment being stored there.
● The call bell system installed by the provider did not consider people's needs. The pitch of the call bells was very high and intrusive for people and staff.
● Communal space was limited; not all people living at the service were able to use the lounge and dining areas.

This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act (Regulated Activities) Regulation 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.

● It was not always clear how decisions in relation to people's care and lives at the service were decided.

● The MCA was not understood to ensure people's capacity was assessed and decisions made in their best interests. For one person, a decision had been made about supporting them with their eating and drinking with no record of how the person's capacity had been assessed or a best interest decision reached.

● People were often admitted to the service on a short term or respite basis either from home or hospital. They later lived at the service permanently with no documentation to show how this decision had been reached.

This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act (Regulated Activities) Regulation 2014.

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.

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
- Care was provided in institutionalised, task-centred ways. One care worker told us, "We have lists of when people are due next. We have to check people four hourly for pad checks."
- Staff used non-professional language to describe people and their care needs. For example, describing people that needed assistance with eating as 'feeders'.
- People did not receive emotional support because staff did not have the time to provide this and lacked the skills to provide it effectively. One person told us, "I can't speak with the staff because they're busy doing other things." We observed people that were distressed due to this lack of support.
- People's diverse needs were not always considered.

This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act (Regulated Activities) Regulation 2014.

- Some people and their relatives described positive experiences of care at the service.
- When staff provided kind, patient care, people responded positively to this.

Supporting people to express their views and be involved in making decisions about their care
- People were not supported to make their own choices regarding their daily routines.
- Staff made decisions on people's behalf without checking with them. For example, turning televisions on or off without checking people's preferences.

Respecting and promoting people's privacy, dignity and independence
- People did not always have privacy in their own bedrooms or control over who accessed these. We saw keys hung outside bedroom doors, enabling anyone to enter people's bedrooms against their expressed wishes.
- People were not always respected or treated with dignity. For example, one person had no clothing on their lower body because staff were concerned about soiling their clothing. When we raised this with management they did not recognise the impact this had for the person's dignity.
- People were not supported to maintain or gain independence.

This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act (Regulated Activities) Regulation 2014.

Requires Improvement

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 good. At this inspection this key question has now deteriorated to 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 records and practices did not promote person-centred care. It was not always clear who had been consulted or involved in decisions about people's care.
- Staff were not encouraged to explore how people would like to be supported.
- People's monthly care reviews did not capture their changing needs or support requirements.
- Staff were not responsive when people requested assistance. Call bells could be heard throughout the service. People told us they knew they had to wait for care. One person said, "Staff aren't quick to respond to calls. They come eventually, sometimes they don't come if they are busy." Another person told us, "If I can't wait I may have a wet [incontinence aid]."

This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act (Regulated Activities) Regulation 2014.

- People felt some of the staff understood their needs. One person told us, "The staff here know me, they give me time to remember things and think what I'm doing."

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

- People spent long periods of time socially isolated or without meaningful activity or stimulation. One person said, "There aren't many activities going on, I do card games sometimes."
- People were not supported to access the wider community as staff were too busy to support this.

This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act (Regulated Activities) Regulation 2014.

End of life care and support

- Care plans did not always detail people's advanced wishes for end of life care.
- Management told us some people required end of life care. There was no information from healthcare professionals to support this.

This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act (Regulated Activities) Regulation 2014.

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.

- People's communication needs were not always understood. Staff did not always know how to communicate effectively with people with dementia.
- Consideration had been given to one person's communication needs, with information displayed in their bedroom to support staff to engage with them.

Improving care quality in response to complaints or concerns

- Management and the provider had not been responsive to concerns highlighted during the inspection.
- Relatives felt able to approach staff with concerns and that these would be addressed.

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 this key question was rated as good. 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.

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

- The provider's oversight of the service was ineffective.
- There was a lack of oversight and monitoring of the service. An audit system had not been introduced and established to monitor safety and quality across the service and drive improvements.
- Significant widespread concerns relating to health and safety, risk and people's hydration had not been identified. The provider had failed to take appropriate action in response to known risks in line with professional guidance. We wrote to the provider following the shortfalls identified on day one and two of the inspection. They were not responsive to the issues highlighted. This left people at risk of potential harm.
- Accurate, complete and up to date care records were not in place for people.
- Investigations and audits were not robust, fully recorded or managed appropriately to mitigate future risks to people.
- When areas for improvement had been identified these had not been developed into an action plan so that they could be introduced in a considered way and progress monitored.
- The previous registered manager for the service had been absent from the service regularly from October 2018 until March 2019 without appropriate management cover in place.
- Appropriate action was not always taken to safeguard people and investigate staff disciplinary matters consistently. We asked the head of operations to make two DBS referrals to prevent unsuitable staff working with vulnerable adults in the future.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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 did not promote a culture in which high quality, person-centred care could flourish.
- Senior management were resistant to challenge and debate.
- Some staff recognised changes were needed but were not receiving management support to put these into effect.
- Staff were extremely concerned and upset during our inspection that they may have placed people at potential risk of harm because they were not aware of and were not following best practice guidance.

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

- Staff suggestions to make improvements to the home were not encouraged or considered.
- A monthly newsletter was used to inform relatives of events and changes that had happened at the service.

Working in partnership with others

- There was limited evidence of partnership working.
- Managers lacked understanding of the role of other professionals and how to work effectively with them.
- The service did not have links to the local community to support people to continue to be part of their local area.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to provide care to service users that was appropriate, met their needs and reflected their preferences. (1)(a)(b)(c)(3)(a)(b)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not treat service users with dignity and respect. Service users were not given privacy and did not have their independence supported. (1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure people consented to their care or follow the Mental Capacity Act 2005 for those who were unable to consent. (1)(2)(3(4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured the premises were suitable for the purpose in which they were being used.

(1)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure staff had the qualifications, skills and experienced required for their work and that appropriate recruitment checks were undertaken. (1)(b)(3(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not have sufficient numbers of qualified, competent, skills and experienced staff deployed. Staff had not received appropriate support training or professional development. (1)(2)(a)

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to provide care in a safe way for service users, assessing risks to their health and safety and doing all that is reasonably practical to mitigate these. The provider had not ensured the premises were used for their intended purpose in a safe way. (1)(2)(a)(b)(d)(i)

The enforcement action we took:

Conditions and NoP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have systems in place to effectively assess, monitor and improve the quality and safety of the service and mitigate. Accurate, complete and contemporaneous records were not in place for each service user. (1)(2)(a)(b)(c)

The enforcement action we took:

Conditions and NoP