Coate Water Care Company Limited

Downs View Care Centre

Inspection report

Badbury
Swindon
Wiltshire
SN4 0EU

Tel: 01793740240
Website: www.coatewatercare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Downs View Care Centre is a residential care home registered to provide accommodation and personal care to elderly people. At the time of the inspection 43 people were using the service. Downs View Care Centre can support up to 51 people.

People's experience of using this service and what we found
Medicines were administered safely, however, they were not always stored safely.

Risk assessments and care plans were in place for each person. Although risks to people had been identified, the steps to be taken to deal with those risks were not always clear. Care plans did not always give enough detail to staff to enable them to manage those risks.

People's social needs were assessed, however, social activities were provided irregularly for people who were bed bound. Some people's relatives told us they had concerns regarding lack of person-centred and dignified care and poor communication with the service.

The service completed audits and checks; however, these were not always effective at identifying concerns.

People were protected by the provider's recruitment procedures. The provider made appropriate pre-employment checks to ensure that only suitable staff were employed. Staff understood their responsibilities in terms of safeguarding and knew how to report concerns if they suspected abuse.

Within the context of Covid-19 infection risk, procedures were in place to ensure infection control was managed. Staff understood their responsibilities to reduce the risk of spread of infection.

The home had a robust complaints policy and records showed complaints were responded to in line with it. People and their relatives told us they knew how to make complaints.

Staff praised the registered manager who promoted a culture of openness and transparency within the service. The registered manager worked alongside professionals to ensure people's health and wellbeing were maintained.

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 outstanding (published 19 March 2020).

Why we inspected
We undertook this 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 incidents between residents, alleged neglect, poor catheter care and poor management of medicines. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with poor storage of medicines, care planning and risk assessments so we widened the scope of the inspection to become a focused inspection which included the key questions of safe, caring, responsive and well-led.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions, therefore we did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from outstanding to requires improvement. This is based on the findings at this inspection

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.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
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 to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified a breach in relation to safe care and treatment at this inspection.

Please see the action we have told the provider to take at the end of this report.

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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our well led findings below.

Downs View Care Centre

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.

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

Inspection team
This inspection was carried out by three inspectors, one medicines inspector, and two Experts 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
Downs View Care Centre 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.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and

improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We reviewed a range of records. These included care plans for four people and multiple medication administration records (MARs). We spoke with three people, five members of staff, the registered manager, the nominated individual and the operations manager. We checked a variety of records relating to the management of the service including accidents/incidents logs and records relating to management of medicines. We observed how staff interacted with people providing them with care and support.

After the inspection
We contacted 12 relatives of people living at Downs View Care Centre. We reviewed documents relating to health and safety, staff meeting minutes, quality assurance audits and action plans.

Requires Improvement

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

● Protocols were available to guide staff on when it would be appropriate to administer medicines which were prescribed to be taken 'when required'. However, some lacked person-centred detail on when the medicine should be administered. This meant staff may not give doses of medicines as intended by the prescriber.

● People could look after their own medicines at the home, we saw this had been recorded in the care plan but the risk assessment and the lockable storage as recommended by the medicines policy was not available.

● Some people were receiving covert medication. This meant hidden in food or drink and given to them in their best interest. Documentation was in place to show that people's mental capacity had been assessed and their best interest had been decided with the involvement of a healthcare professional and family members. However, there was no evidence that pharmaceutical advice had been sought on the best way to administer these medicines as recommended by their policy. This meant there was no reassurance the medicine would remain fully effective if for example mixed with an inappropriate food or drink.

● Fridge temperatures had been recorded daily, however the minimum and maximum temperature had not been recorded. The records could not give assurance that medicines were being stored at the temperatures recommended by the manufacturers. When we checked the thermometer on the day of inspection, the minimum and maximum temperature was outside the recommended range.

● Access to medicines were not restricted to authorised staff. There were not suitable arrangements for storing and recording medicines that required extra security. We saw that one medicine had not been stored in the correct cupboard. The locked cupboard had the key stored in the lock on the day of the inspection, so access was not restricted. We found that the records did not correspond to the quantities available for two medicines.

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

Assessing risk, safety monitoring and management

● Risk assessments and care plans did not always identify potential risks to people. For example, one person's catheter care plan and risk assessment did not mention the risk of or possible signs of sepsis.

● There was a system of recording that included risk assessments and care plans. However, documentation relating to people's care needs was difficult to follow. Neither key areas of risk nor instructions or guidance for staff on how to manage the risk was presented in a logical pathway. For example, one person had a history of seizures. Although there was an appropriate risk assessment in place, it failed to state the type of

the seizure, any limbs involved and staff's appropriate responses.
● During our inspection we found that not all known risks had been assessed by the provider. For example, one person was at risk of scalding from hot liquids. There was no appropriate risk assessment regarding the person in spite of the fact they had suffered a second degree burn from hot soup.
● Information about risks and safety was not always comprehensive. One person's behaviour risk assessment stated they could exhibit behaviour they displayed when in distress which could be aimed at staff and others. Staff did not always have the relevant information and training to keep themselves and others safe. We looked at a person's risk assessment which mentioned distraction techniques but did not state what these were. However, no observation of the person was suggested to ensure others were safe.
● We asked the registered manager and a visiting professional who stated that staff did not need to have training in how to use restraint if it were required as a last resort to keep themselves and others safe. The visiting professional said in those instances the person should be given 'space'. However, it was unclear how other people in the service who could be at risk from the person would also know this. Therefore we were not assured that all information was in place to mitigate these risks.
● We observed a person during the lunch period. The person accidentally knocked a drink off their table which spilt into the walking area of the lounge. Staff walked past that and it remained unnoticed for five minutes. This was a potential slip hazard.
● The provider did not ensure appropriate action was taken to manage environmental risks. For example, we saw an assessment of moving and handling equipment was completed in March of this year. The assessment highlighted a number of actions, such as a shower pump was defective, the back-up battery flat, two air jet covers missing off a bath, brakes worn out on chair scale and a mobile hoist carabiner needed to be upgraded. At this inspection we found none were actioned.

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

● Possible risks to people in relation to the environment were managed through a series of internal checks and external servicing. Personal emergency and evacuation plans (PEEPs) were in place in case of an emergency for each person. These included details of how the person should be supported in the event of an evacuation.

Systems and processes to safeguard people from the risk of abuse
● People living at Downs View Care Centre and their relatives told us they felt safe. One person's relative told us, "I have found on a number of times that she is well looked after."
● Staff were aware of the policy and procedure to follow if they suspected or witnessed abuse. A member of staff told us, "If I witnessed a case of abuse, I would tell a senior member of staff and if it didn't go anywhere, I would go to [the registered manager]."
● Staff received training in safeguarding people from abuse and safeguarding reporting.

Staffing and recruitment
● The provider followed a thorough recruitment procedure. Disclosure and Barring Service (DBS) security checks and references were obtained before new staff started their probationary period. These checks help employers make safer recruitment decisions and prevent unsuitable staff being employed. However, we found gaps in the employment history of two staff members.
● People, their relatives and staff provided us with a mixed feedback on staffing levels. One person told us there were 'constantly low' staffing numbers.
● The service was using a dependency tool to inform their staffing levels, however, we saw that during our inspection staff struggled to meet people needs. For example, staff did not always have enough time to

interact with the residents providing them with meaningful activities or a longer conversation. This meant whilst the assessed staffing levels could be deemed as safe were not sufficient to effectively meet people's needs.

Learning lessons when things go wrong

● Lesson had not always been learned on the provider's level. Earlier this year we inspected a sister home of this same provider. We found there that full employment history was not always sought during the recruitment process. The provider failed to share their findings and to ensure they obtain full employment histories for all staff working at Downs View Care Centre.

● An audit was completed in May 2021 regarding a weight loss as a person was noted to have lost a considerable amount of weight. There was no timescale regarding the exact period in which the weight loss had accrued, or any actions taken as a result.

Preventing and controlling infection

● One of the operations directors arrived at the service in the afternoon. Upon entering the office, they were not wearing any personal protection equipment (PPE) such as a mask or an apron and had to be prompted by the other operations director to put this on. They were assisted by a member of care staff with this. Later on in the afternoon, we saw the operations director again walk through the home with no mask on. This contravenes the current guidance regarding safe use of PPE.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

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 outstanding. 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

- We observed how people were being assisted during their mealtime. Although people were assisted appropriately in one unit, some people in the other unit did not receive relevant support. We saw a person was served a meal at 12:15. We did not see any choice being provided prior to this. The meal was put in front of the person and cut up, and then the staff left. We observed the person struggling to consume their meal and eventually give up. They attempted to eat again at 12:45 but failed. We saw staff pass by the person at least 10 times and no one noticed the person had not touched their meal. At 1 pm we informed the registered manager that the person had not been able to eat their meal. The registered manager shouted for a member of staff to help. We then pointed out that the meal would have been cold by now. The registered manager asked for the meal to be heated and assistance given. We checked the person's care notes which stated they must be assisted with all meals.
- We saw that the low staffing levels made it impossible for staff to have a chat with people and to engage them in a meaningful conversation. This meant the provider did not ensure people received appropriate support that met their needs as staff were only able to focus on tasks.
- Staff told us they respected people's differences and provided them with person-centred care that reflected their protected characteristics. The Equality Act 2010 introduced the term "protected characteristics" to refer to groups that are protected under the Act. It is unlawful to treat people with discrimination because of who they are.

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

- People were supported to make day-to-day decisions for themselves. One person told us, "You can choose what you have for breakfast. You can have a fried breakfast or fish or cereal. The food is great, I love it."
- People's relatives told us they were regularly contacted by the service. However, people's relatives pointed out that some information was not always passed to them. One person's relative told us, "I feel now that we chase for information by phoning but I do get information back from staff." Another person's relative told us, "[Person] went to hospital (after a fall) and I visited him there in March. The home did not tell me, the hospital told me about it. The home was a bit slow on that."
- We saw that people's preferences were requested such as when people wanted drinks and sort of bed linen, e.g. quilts or blankets and sheets. People's requests were met promptly by the service.

Respecting and promoting people's privacy, dignity and independence

- We saw one member of staff helping a person eat their meal. They stood right next to another person who did not have assistance to eat their meal. The member of care staff paid no attention to the fact that the

person next to them was not eating at all. At one point the member of staff asked the staff serving food for a napkin for the person they were supporting. They were told to go the toilet and get tissues from there. This lack of provision of napkins or similar paper products showed disregard for people's dignity and respect.

● Staff we spoke with demonstrated commitment to people in the service and the importance of people being well supported. They knew how to promote people's dignity and independence.

● Confidentiality was supported. Information was locked away as necessary in a secure cupboard or filing cabinets. Computers and electronic devices used by the provider and staff were password protected to keep information secure.

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 outstanding. 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 plans did not always reflect people's current care needs and lacked sufficient information and guidance to instruct staff how to provide personalised care. Some members of staff did not know how to access care plans that were stored online. A member of staff told us, "They haven't trained me to access things online and many things are being stored there. Things like life histories to start conversation with residents. For example [person] is obsessed with a bank. Why does he talk about a bank? Did he work in a bank? Did he have his money stolen?"
- Some care plans did not address behavioural needs of people. This resulted in repeated behavioural incidents affecting people living at the service. One person told us, "There is a person who continually urinates in the corridor, but they don't do anything about it. A few days ago he was walking down the corridor and just dropped his trousers and urinated on the floor. The place stinks but nothing is done."
- The care plans and risk assessments were regularly reviewed. Most relatives of people told us they were involved in people's care and they took part in the reviews of people's care plans.

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.

- Individual communication plans and guidelines on how to communicate with people were in place.
- Staff were knowledgeable about people's communication support needs and people were given information in accessible ways.

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 who stayed in their rooms lacked any social interaction. One-to-one activities were impossible to be provided to bed bound people due to current staffing levels. A member of staff told us, "We have an activities lady but lately she is doing care instead of activities."
- We asked one person what they thought about activities. The person told us, "I don't know that I would join in any activities as I'm not sure they would be suitable. But there are no activities to speak of so difficult to say."
- People were supported to maintain relationships that mattered to them, such as family and friendship. Staff encouraged communication with relatives via phone calls or multimedia calls.

Improving care quality in response to complaints or concerns

● We saw the complaints log which detailed four complaints over the past two years. However, it was not clear how any changes to practice needed were passed onto staff. There was no evidence of discussing complaints in team minutes records.

● Staff were aware of the complaints policy and told us they would immediately help people to raise an official complaint if needed.

● People and their relatives knew how to raise any complaints or concerns about the service provided, and told us they felt comfortable doing so.

End of life care and support

● None of the people currently living at the home required support with end-of-life care at the time of the inspection.

● Although people had end-of-life care plans in place, these provided staff with conflicting instructions. For example, one person had the 'do not attempt cardiopulmonary resuscitation' (DNACPR) form in place. However, the end-of-life care plan for that person instructed staff to resuscitate them until paramedic arrive.

● The registered manager told us they would respond to any wishes or advance wishes they were made aware of should they support anyone with end-of-life care. They also said as needed contact would be made with other appropriate services.

Requires Improvement

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- We found at this inspection the monitoring of the service to be not always effective at identifying where the quality and the safety of the service were being compromised. Even though the systems for monitoring care quality were in place, the concerns regarding people's risk assessments and storage of medicines remained unnoticed and unaddressed by the provider.
- Records to document the care people had received were not always well-maintained. People's records sometimes lacked important information.

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

- The registered manager was well known throughout the home and people told us they liked them. We noted that the manager provided support to people and knew them well. The registered manager was able to demonstrate an in-depth knowledge about the people they supported and the staff team working at the service.

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

- The culture of the service was mainly task-focused which lacked attention to enhancing the daily lives of people and providing care which put the needs, wishes and choices of people at the core of how the service was run.
- We asked people, their relatives and staff about their opinion on the management of the service. We received mostly positive feedback. One person's relative told us, "The registered manager is totally approachable. She is brilliant."

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

- The registered manager understood the 'Duty of Candour.' This regulation sets out specific requirements that providers must follow when things go wrong with care and treatment. These include informing people and their relatives about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
- The provider had failed to submit notifications of certain incidents to CQC which they are legally required

to do.
● Throughout our visit the registered manager and staff were keen to demonstrate their practices and gave unlimited access to documents and records. Both the registered manager and staff spoke openly and honestly about the service and the challenges they faced.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People's relatives were encouraged to provide feedback on their experience of visiting people using the service via a survey. However, the survey was limited to the use of PPE, testing for COVID-19 and general presentation of the person visited. The quality of support from staff was not being surveyed. One person's relative told us, "Couple of weeks ago a member of staff was in the room with [person] and when [person] tried to speak, the carer spoke over her and appeared to be rushing her. 'Drink your drink, you have to say good-bye.' It had only been 15 minutes, she kept trying to rush [person]. [Person] did stay to complain of a sore on the top of her leg. The carer said 'you must have just bashed it' and [person] went quiet and didn't say any more. She would normally talk, normally she is chatty"
● A staff survey had been undertaken in February 2021. There was a number of comments made in relation to results. However, the 'Action plan following employees survey' was blank. Therefore, it is uncertain how these actions would be completed and by whom.
● Staff said that there was an open culture within the service as they knew their views and opinions were always taken into consideration by the registered manager. However, they said that low staffing numbers were affecting the registered manager's ability to operate effectively. A member of staff told us, "I like her but she doesn't seem to have enough time. There is so much work on. Now she has got admin staff but before she had to do it all without any support."

Continuous learning and improving care; Working in partnership with others
● The provider had failed to monitor and improve the culture of the service. Care was not person-centred and people were not always cared for in a safe way.
● During the pandemic the provider had been working with Public Health England to help ensure they were up to date with guidance.
● The service had developed a contingency plan which considered the risks of a range of incidents that could affect the safe running of the service. The infection control policy had been updated to consider the risks associated with the coronavirus.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure the proper and safe management of medicines. The provider failed to asses the risks to the health and safety of service users of receiving the care or treatment.

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 effective systems and processes in place to make sure they assessed, monitored and improved their service to ensure people received safe care. Records relating to the care and treatment for each person were not always accurate and up to date