Richmond Fellowship (The)

Moor View

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Moor View is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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.

Moor View is a nursing home which accommodates 17 people, living with complex poor mental health in one main two-story adapted building with two adjacent bungalows. The home has garden areas.

There was a registered manager at the home, although they were not present during the inspection because they were on leave. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection in October 2015, we rated the home as 'good'. At the time of this inspection, the home was in the process of changing from a residential care home, to a service which provided rehabilitation and re-ablement. There had also been a period of unsettled management and we found there were weaknesses in how the home was being run. We identified three breaches in the regulations, relating to regulation 12 safe care and treatment, regulation 13 safeguarding people from abuse and improper treatment, and regulation 17 good governance.

Recruitment of staff was in progress and there were satisfactory procedures in place to make sure staff were suitably checked before working with vulnerable people.

Risk assessments were not always clear or well organised in people's support plans and some risks were not adequately assessed. Records to show premises and equipment had been checked for safety were not robustly in place. Accidents and incidents were not thoroughly recorded or concerns appropriately reported.

Support for staff to carry out their roles was in place, but not always consistent or sufficient for all staff. Staffing levels were satisfactory to meet people's physical needs, but not to support them with skills in independence or activities they wished to do outside the home.

People were mostly supported to have maximum control and choice over their lives and staff supported them in the least restrictive way possible. Policies and systems in the service supported this practice, and although staff understood legislation around people's mental capacity, documentation for consent and decision making was not robust.

Staff had a kind and caring approach and showed respect when interacting with people and good regard for people's privacy and dignity. Staff had discussions with people about their daily routine, although there was limited evidence of people being involved in their own care planning or discussing future goals.

Systems and processes for assessing and monitoring the quality of the provision, including identifying risk, were weak. Audits were not robust and there was little evidence of management oversight of the service.

The overall rating for this service is 'Inadequate' and the service therefore is in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There was insufficient assessment or mitigation of risks, to individuals and in the service.

Safeguarding procedures were not followed promptly and there was inconsistent reporting of concerns.

Staffing levels were satisfactory to meet people's physical needs, but not to support them with skills in independence or activities they wished to do outside the home.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had inconsistent support to carry out their roles.

Staff understood the requirements of the Mental Capacity Act, but documentation around this was not always robustly in place.

People enjoyed their meals and their dietary needs and preferences were known.

Is the service caring?

Good

The service was caring.

Staff had a kind and caring approach.

People's dignity and privacy was respected.

Staff understood people's need to be independent.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were not always reflective of people's needs and information was poorly organised and at times not accessible to

staff.

People had limited opportunities to engage in meaningful activities according to their individual needs.

The complaints process was available and people knew how to complain.

Is the service well-led?

Inadequate

The service was not well led.

There was inconsistent leadership and management in the home, with no oversight of clinical practice. Record keeping was not robust.

Staff were unsettled by changes to the service and there was no clear support in place for staff during this time.

Systems and processes to monitor and assess the quality of the service were weak.

Moor View

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 18 and 27 September 2018 and was unannounced on the first day.

There were two adult social care inspectors and a mental health inspector on the first day. There was one adult social care inspector on the second day.

Before the inspection we reviewed information available to us about the service. The previous registered manager had completed a Provider Information Return (PIR). The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed safeguarding alerts and notifications submitted to us by the service. A notification is information about important events that the registered provider is legally required to send us. For example, where a person who uses the service suffers a serious injury. We took this information into account when we inspected the service. We contacted the local authority safeguarding and commissioning teams and the clinical commissioning group (CCG) who told us what they knew about the service.

We spoke with three people using the service, one visitor, five staff, the provider's locality manager and the provider's regional manager. We observed care in the home and completed reviews of records. These included 16 care records and documents associated with how the home was managed.

Inadequate

Is the service safe?

Our findings

Staff we spoke with said they understood how to identify and report any safeguarding concerns. However, we found risks to individuals were not always recognised or mitigated safely. We looked at accidents and incidents recording and found there were several concerning entries which showed people had not been cared for in a way that ensured their safety. For example, one concerning incident had not been referred to the safeguarding authority and the individual risk assessment had not been updated to ensure the situation did not occur again. We were also aware of a serious incident which had occurred but not been reported to us in a timely way. There was no indication of lessons learned or investigations by the provider and we asked for this information to be sent to us following the inspection. The management team took prompt action to begin to address this without further delay. The regional manager told us staff did not always recognise situations or incidents that needed to be referred to the local authority safeguarding team and they were addressing this.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The regional manager told us there had been a lapse in management oversight over recent months since the previous registered manager left the service. We asked the regional manager to immediately review all their records of accidents, incidents and daily records to identify whether there were further safeguarding matters which needed to be addressed and to assure themselves people were receiving safe care. We found this work was being carried out between the first and second day of the inspection and the regional manager assured us they were working with the local authority to report any safeguarding matters.

People we spoke with said they felt safe living at Moor View. One person said, "I do feel very safe here. The staff help with that." Another person said, "I'm safe here because the staff know me."

Staff we spoke with knew the individual risks to people when supporting them with their care. For example, staff were able to tell us which people were at high risk of falls or malnutrition. However, people's care records showed there were individual risks which we found had not all been assessed thoroughly. For example, for one person we saw there was a single line entry in their record which indicated risks of self-harm which were not reflected in the care plans. Where another person required two members of staff to support them to ensure adequate safeguarding precautions, this was not detailed. Where we asked to see observation records for people at high risk of falls, these were stored but scattered throughout the electronic system and would therefore not support any lessons learned analysis.

The home was in need of some refurbishment and the provider said this was planned in line with changes to the model of care intended for people at Moor View. The provider was unable to evidence how premises had been safely maintained. For example, the electrical installation certificate from 2015 was shown as 'unsatisfactory' but there was no update to show anything had been done about this. The fire risk assessment was only valid until September 2017 and there was no updated version available. We received some additional concerns following a West Yorkshire Fire and Rescue Service fire officer's visit after our

inspection and there had been an urgent notice to improve issued. The provider sent us a detailed action plan which stated how they were responding to the fire services concerns.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with said there were enough staff to support their physical care needs, but not always enough staff for them to have their other needs met, such as for them to be able to go into the community with support. We found there were not always enough staff to meet people's needs. The provider told us they were in the process of recruiting to fill vacancies to ensure there were sufficient staff with the right skills to support people. We found there were only a limited number of staff employed with the clinical knowledge to support people's nursing needs and there was no oversight of clinical practice in the home. The provider told us they were working to address this and had commenced recruitment for a suitable member of senior clinical staff.

Medicines ordering and supplies were managed appropriately via the GP and pharmacy, including controlled drugs. We saw systems in place to ensure medicines were securely stored and accounted for. We checked stock balances of controlled drugs and these were accurate. Medication administration records (MARs) had been fully completed. The clinic room was tidy and well stocked, with accessible policies and procedures available for medication. Staff took time to support people with their medicines individually and each person had a locked medicine box in their own room. Weekly audits of medication including medicines as required, was carried out by the nurses.

The environment was visibly clean and there was an appropriate supply of personal protective equipment for staff to use, such as disposable gloves and aprons.

Requires Improvement

Is the service effective?

Our findings

The management team told us staff supervisions had not always taken place and there were plans in place to improve this. We saw evidence some staff supervisions had more recently been carried out and documented in a meaningful way. There was limited consistent supervision for clinical staff although there were opportunities for them to access external peer supervision. We were told of plans to improve clinical supervision and support, and this was being addressed through recruitment.

We looked at the staff training information and we were told some training was e-learning and other training was classroom based, such as challenging behaviour training. We saw there were some gaps in the training matrix and we were told this was where some staff had been absent. There was some training which we were told staff had to complete, such as safeguarding training.

Staff told us they regularly accessed training and they said they had opportunities to discuss their training needs with managers. We saw the provider's annual refresher training programme and competency framework for operational staff and managers. This set clear expectations for training and skills.

Staff told us they had completed e-learning training to help them understand mental capacity. Staff we spoke with had an understanding of people's mental capacity and the legislation regarding people's rights. Staff told us they were aware people had the right to make unwise decisions and they understood the need for best interest decisions if a person lacked the mental capacity to make decisions on their own.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are 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 were being met.

However, there was limited evidence of mental capacity assessments in some people's care records having been completed. We saw reference in one person's record to show a mental capacity assessment needed to be carried out, but it was not clear by whom or when. Where people had DoLS in place, we saw this was documented. There was reference in people's care records to best interest meetings, but records were not clear as to how specific decisions had been reached.

We looked at documentation relating to the Mental Health Act. We saw where one person was on a community treatment order (CTO), the care plan reflected the requirements of the CTO. Where the person

was on Section 17 leave we saw the authorisation for this was complete and accurate. However, the leave form was not reviewed in a timely way.

The recording of people's care and their rights did not have sufficient management oversight and there was limited evidence of effective audits of care documentation.

We found there was a positive coordinated approach to working with other professionals in support of people's health. For example, the Community Mental Health Team (CMHT), the psychiatrist and GP. People's health needs were supported through appropriate referrals where necessary. For example, people were offered appointments for routine screening and there were referrals to pain management clinic, respiratory clinic, district nurses and mental health teams. We saw however, care plans did not always reflect current health needs. For example, for one person there was evidence of the district nurse being involved in catheter care, but no corresponding care plan about how this was being managed.

One person told us they were very well supported with their diet and nutrition. They said they had needed to lose some weight and the staff had supported them. They said, "The food's alright here. I needed to have smaller portions and the staff helped me with getting to my preferred weight."

Staff knew people's dietary needs and people had access to suitable food and drinks relevant for their needs and preferences. We saw one person was microwaving their meal and they told us this was what they preferred, but said they could ask the cook for anything any time. We saw people knocked on the kitchen door and chatted with the cook frequently, to ask what was being cooked and to express their choices. We saw the cook was very involved with asking people their preferences and they adapted the menus according to what people told them.

We spoke with the cook and they understood people's individual needs. The kitchen was very well organised and the cook knew each person's dietary requirements as well as their likes and dislikes.

Good

Is the service caring?

Our findings

Staff were caring in their approach and interacted with people in kind and supportive ways. People we spoke with said they felt staff cared about them. One person said, "They're like family." Another person said, "The key thing here is the staff. They do care."

Staff chatted with people about matters affecting them, such as who would be coming to visit them, or where they were planning to go. We saw one person became unhappy when their visitor had not arrived to take them out and staff noticed this and offered reassurance.

One person for whom English was not their first language, had an interpreter who attended regularly to support them. We saw there were key words in the person's own language on notices around the home, such as for fire exits, although this did not extend to other information, such as menus. Care records highlighted people's faith, gender, gender identity, sexuality and preferred name.

Staff were mindful of people's privacy and dignity and they asked people's permission before entering their rooms. One person told us they liked having privacy to meet with their visitors and said staff respected this. We saw when staff took a phone call from one person's relative, they gave the person the phone and encouraged them to take the call privately.

We saw there was a notice displayed to show how advocates could be involved with people's care and support and on the day of the inspection, one person was visited by their advocate.

The provider told us there were plans for refurbishment of the home and we found the environment was not very homely. For example, in the dining room there was a bare lightbulb. Staff told us people chose the colour of their bedroom door. There were kitchen areas for people to make their own drinks and we saw people used these areas.

Requires Improvement

Is the service responsive?

Our findings

Information about people's care was stored electronically, although we found this was not in any logical order and so we had difficulty locating key information, as did staff who assisted us with this. Care records and support plans were not completed with sufficient detail to guide staff how to support individuals' needs. For example, one section in a persons' record entitled 'needs and risk assessment' was not completed at all. Another person's record stated 'staff to encourage' but did not suggest how staff might do this or what would be appropriate encouragement for the person. Another person's care record stated staff were to encourage the person to do gentle stretching exercises and hold their head up when walking, yet this was not reflected in their support plan.

We saw some detail about people's needs, such as risk, was not captured in the care planning process. We found some information was out of date and would be misleading to anyone reading the care plan if they did not know the person. For example, one person's record stated they had a broken bone, but this information had not been amended when the person's injury healed.

Care plans were reviewed, although not regularly or recently; for some care plans there had been no reviews since May 2018 and in others, August 2017. We found little written evidence of people having contributed to their care planning, although two people we spoke with said they did not wish to be involved. One person said, "I know there is some paperwork, I'm not bothered about all that."

Activities were dependent upon which staff were available to support people and there was little focus on enablement activities to encourage people to develop their independence and practise self help skills. There were no clear record of what goals or outcomes people were aiming towards.

One person told us they enjoyed spending time with staff and other people who lived in the home. They said, "Every Sunday we shop and make a meal here. We cook and eat it together, I like that". Another person said they enjoyed being able to access a chess club which they enjoyed.

We saw there was a complaints process accessible in the communal areas and feedback, either positive or negative was encouraged. The management team told us there had been no complaints received at the service. People we spoke with said if they wanted to raise a concern they would feel comfortable to do so with any of the staff. One visitor we spoke with said there was always a staff member around and they would address any concerns to them.

Inadequate

Is the service well-led?

Our findings

There was a registered manager who had been in post since April 2018 and was on leave at the time of the inspection. There was a changing management structure in the service and this process was ongoing. The running of the service was being supported by the two team leaders in the registered manager's absence. There was input from senior managers within the organisation, such as the regional manager and the locality manager. At the time of the inspection, there was active recruitment in place for a clinical lead to support the running of the home and provide effective clinical oversight.

The provider's regional manager and the locality manager told us the service was undergoing a period of transition, from a care home to a rehabilitation and recovery service. As such, they were working towards a new model of care and this involved changes for people who lived at the service as well as the staff team. The management team said they understood staff were currently unsettled and they were working to ensure support was consistent. They told us they were working to ensure the management of change was as least disruptive as possible.

Staff we spoke with said they did not always feel supported to carry out their role due to the many changes and management instability. Care staff roles had recently changed to 'recovery workers', with the intention of promoting more independent living for people. However, staff expressed some frustration because they felt staffing levels did not currently enable them to support people in this way.

Some staff we spoke with said they did not think the changes were being managed well; some staff said the changes would not be appropriate for some of the people who had lived at Moor View for a long time. The management team told us there had been individual planned assessments carried out and the service was working closely with the Clinical Commissioning Group (CCG) to make sure every individual had the necessary support. We spoke with the CCG as part of our inspection process and they confirmed they were working closely with the provider to support the changes to the service.

People we spoke with said they thought the staff on duty ran the home well. However, they said they did not see the registered manager very often. One person told us, "I've met him and shaken his hand but that's all I've seen of him." Another person said, "I don't know who the manager is here."

We found there were weaknesses in the systems and processes to assure the quality of the provision. Audits were not robust or consistent; where audits were carried out, these lacked regularity and there was weak recording of actions. For example, one audit showed actions 'should be completed by end of June 2018' but there was no evidence of any follow up or by whom. There were limited infection prevention and control audits and no evidence of any mattress checks. Health and safety daily checks were done by the recovery workers but there was no evidence of any manager oversight of these within the home, or actions to be addressed.

Information governance was poor. There was no logical system for naming electronic documents, which meant outdated information was stored with recent information. There were links within the electronic

system which did not open up further information as intended. Records to support how safely the home was managed were inconsistent and not organised well. Care documentation was held electronically but not organised in such a way for information to be retrieved easily. Agency staff did not have access to electronic information and this was something the management team told us they were working to improve.

There was poor oversight of clinical practice in the home. There were registered nurses in post to support people's health needs with one on duty each shift. However, there were no senior staff available to support the nurses in a professional capacity and oversee their practice.

There was poor oversight of risks and little action taken to identify risks to individuals or report concerns appropriately. Statutory notifications the provider is obliged to send to CQC about specific incidents, were not sent in a timely way.

The above examples show there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team had begun to identify areas of weakness through being present in the service and they were proactive in taking steps to address the areas of concern highlighted through the inspection.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not well identified or mitigated, to individuals and within the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding concerns were not robustly identified and acted upon.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems for assessing and monitoring the quality of the service were not robust.