MMCG (2) Limited

River View Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook an unannounced focused inspection of River View Care Centre on 3 December 2018. This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our September and October 2018 comprehensive inspection had been made. The team inspected the service against two of the five questions we ask about services: is the service well led and is the service safe? This is because the service was not meeting eight legal requirements at their last inspection.

No additional risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity, so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

River View Care Centre is a care home with nursing, which provides services across three floors that are further split into seven units. The care home specialises in providing a service to older adults who may be frail due to age or disability as well as individuals living with dementia. 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. The service is currently registered to provide accommodation to a maximum of 137 residents. Following the last inspection rating of Inadequate, the service was placed in special measures. A restriction was placed on new admissions, which meant the service was unable to accept any new people to River View Care Centre. CQC imposed a further three conditions on the service. Two of these were met within the stipulated time frame. One condition remains outstanding, with the Commission accepting the reason presented for the delay. The restriction on admissions remains in place until agreed otherwise by CQC.

The service has a registered manager. A registered manager is a person who has registered with CQC 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.'

The service remained unsafe. People were not kept safe from the risk of harm. Documentation was poor and conflicting in information, and staff were unable to provide assurances as to their understanding of the individual risks associated with people's care and support needs.

People were not appropriately monitored for adequate food and fluid intake and weight checks. As a result, potentially people did not have referrals made to external professionals in a timely way. Where bedrails were required to keep people safe, these were not always used. Staff attended to people, but failed to recognise the risk the lack of bedrails presented.

Staff were unaware of people's changing health needs. Documentation, although stated as reviewed and therefore up to date, was inaccurate and not reflective of people's needs. This meant that people were

potentially exposed to unsafe care and treatment.

Governance of the service remained inadequate. Current systems and processes used as part of the audit process by the service were not effective in monitoring, assessing and improving the quality of the service. Where audits had been carried out in relation to people's care plans and risk assessments, these had failed to identify inaccurate and misleading information.

Poor staff knowledge of people and safe practice, in addition to inaccurate documentation, raised concerns in relation to staff professionalism. These issues were discussed during the inspection with management.

The service remained in breach of Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service remains in Special Measures.

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.

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 remains Inadequate.	**Inadequate**
Is the service well-led? The service remains Inadequate.	**Inadequate**

River View Care Centre

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 was planned to check 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.

The inspection was prompted in part by five notifications following which a person using the service died and another developed a serious medical condition. The death is subject to an investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incidents indicated potential concerns about the management of risk and determining when referrals to external agencies needed to be made. This included focusing on the risk of falls, malnutrition, falls from beds and management of complex behaviours. This inspection examined these risks.

This inspection took place on 3 December 2018 and was unannounced. The inspection was completed by two inspectors.

We requested and took into account local authority reports and details of any significant issues. We further received four complaints about the provider. We spoke with several placing authorities and requested their feedback. We found that several areas of concerns were identified.

During the inspection we spoke with five members of staff, five people who use the service and three visiting professionals.

We made further general observations throughout the day of the inspection, including during a medicine round. Records related to people's support packages were seen for five people. In addition, we looked at a sample of records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

We have inspected this key question to follow up the concerns found during our previous inspection of September and October 2018. And in response to several notifications the Commission received that raised concerns of continuing unsafe practice. This resulted in five alerts made by the Local Authority to the Commission, that identified people were not being provided with care that was safe, and responsive to their changing medical health needs. At the last inspection the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found, that whilst some of the issues had been resolved, specifically linked to the environmental concerns, other items remained in place. These continuing issues focused on how to keep people safe, and whether this could be evidenced in writing and / or staff knowledge. We found that sufficient deficiencies were in present in this area. As such, the service remained in breach of Regulation 12 of the Health and Social Care Act2008 (Regulated Activities) Regulations 2014.

As part of the inspection process we completed a tour of the premises, to determine if any changes had been made to the physical environment following the last inspection. We found that call bells were no longer tied up in communal bathrooms. People who were able to use a call bell successfully had this placed within reach. This was often placed on a table, on the person, or on the bed. We visually checked the bedrooms where previously ceilings illustrated a leak in the roof. We found that these had been repaired. One bedroom and one communal corridor nevertheless showed signs of water damage. We were told by both maintenance men that this was possibly as a result of the recent works completed in the loft, where water was tested and required draining. They also stated, to the best of their knowledge, this was not linked with the previous leaking roof. We were further advised that decorators would be coming to the service to redecorate.

Despite the improvements to the physical environment, people were still not kept safe by staff at the service. During the walk around, we noted one person was lying in their bed, facing the wall in a foetal position. Their back was close to the edge of the bed, with a crash mat tucked under. The bedrails were not up. The bed was normal height. Some of these factors, suggested the person was at risk of falls. We spoke with the nurse in charge on the unit, and queried why the crash mat was not correctly positioned next to the bed, and why this was not lowered. We were told the person had been reassessed and no longer required a crash mat, or low-profile bed. The nurse entered the person's room, and removed the crash mat to the office. We checked the person's file in their bedroom, and found a one-page profile, dated July 2018. This referred to the person as being at high risk of falls. A low-profile bed and a crash mat were to be used. We brought this to the nurse's attention who advised that this document was not accurate or in date. We were not provided any additional information, although pointed out it was in their daily folder stored in their bedroom. We found the one-page profile did not document any supplementary information on this person's needs, specifically related to the management of falls. We chose to case track this person, which meant we would look at all their needs, and assess whether the service was doing entirely what was necessary to keep the person safe.

We found that the person's care file contained conflicting information. The person has been assessed and reviewed in October 2018, as being at high risk of falls. However, the management strategy for this was

contradictory within the file. Several documents reconfirmed the nurse's statement, that the person had been reassessed. However, the nurse had failed to mitigate the risk of the person falling, as per these documents, that stated the need for bed rails to be up, with the bumper in position each time the person was in bed. The nurse had seen the person was in bed, removed the mattress, yet failed to raise the bedrails. We walked past after 30 minutes and found the bedrails were still not up. We further found conflicting information in this person's files in relation to their ability to use the call bell. "[name] is unable to use the call bell, keep it within her reach." We queried with the clinical lead what this meant, and were not provided an answer. It was nevertheless acknowledged that this was inaccurate and conflicting. It was unclear how the service would respond to the person if they were unable to use the call bell. Another document read, "[name] continues to be supervised when mobilising to prevent falls." We sought clarification on how the staff could assure themselves that they were always with the person when they were mobilising. We were repeatedly told that staff were with the person when they were mobile. We challenged this belief, querying why the bedrails were not up, and were told that staff had left the person sitting in their armchair. Staff were not aware when the person had risen from the chair, walked to their bed, climbed in, and fallen asleep. This example was used to illustrate three points. It is evident from this incident that it would be inaccurate to suggest that staff supervise when the person is mobilising, as this may not always possible. Although the nurse saw the person was in bed, they had failed to follow the care plan. It was unclear if the nurse's failings were as a result of her not knowing the need to raise the bedrails, or because it was not seen as necessary. Irrespective, this had left a person who was notably at high risk of falls vulnerable, and susceptible to falls.

In another example we found a person was calling for help. We approached the person, who was sat in their bed horizontally, with the bed rails up on both sides. The person was in distress and requested assistance. We pressed the call bell, which had become tangled in the bed linen. We found a member of staff responded within two minutes. However, they were unable to assist alone and therefore requested further assistance. A second member of staff came to help after approximately three minutes. The person during this period raised a number of concerns about the delivery of their care, stating that they were often left alone for long periods of time. They went onto state, "Thank goodness you were here and got me some help." Further down the conversation the person added, "They [staff] just walk past and ignore me. When they do come, they say "oh you're alright" But it's alright for them to say that, they are not the ones stuck." We spoke to this person at length about their experience at the service, and whether this was keeping them safe. They reported, "I am not happy here, it's miserable." We case tracked this person to establish what their specific needs were and whether these were being met as required. We found the care plan contained contradictory information specifically around the person's nutritional needs. We found one care plan dated March 2018, and reviewed thereafter monthly stated, "normal diet and normal fluids." Another care plan dated July 2018 read, "[name] takes a soft diet and normal fluids." Upon observation the person was eating a hard, crisp, biscuit. An empty packet was laid on the table next to them. We queried the inaccuracy, specifically in reflection of the biscuit and were told by the clinical lead that the biscuit was soft food. We queried this, given the type of biscuit being rather dry and crunchy. The clinical lead then responded perhaps it had been dipped into the tea. The person drank out of a beaker. It was evident that the clinical lead was not aware of this. We were then told the soft diet was the person's preference and not a clinical requirement. There was no evidence to verify this. The care plan also stated, "monitor food and fluids". There was no evidence of any monitoring having taken place. With staff being unable to accurately know the person's needs, they were potentially at risk of unsafe practice.

Similarly, for an additional two people we noted that their hydration and nutrition needs were inadequately met. The care plan did not document the amount the person required to drink and eat to keep safe. Both people had high water-low scores, which meant that their skin integrity was compromised and they were more susceptible to develop pressure sores. On some days we saw records of drinks offered were recorded within daily notes. However, nothing was done with this information, irrespective of the quantity being

extremely low, for example on one-day 135ml had been drunk, according to what was recorded. On none of the days where records had been written, could we calculate anyone having drunk more than 650ml. This is noticeably low, especially given the people's specific needs.

In another care plan we noted that a person was recognised to have "poor eating, needs a lot of encouragement". The person on most days would eat only breakfast, which consisted of cereal with cold milk, banana and a cup of tea. Lunch and dinner options would be offered, but declined. The care plan noted the need to monitor the person's weight weekly due to the poor eating, and "monitor food and fluid intake". However, we found that the person was not weighed weekly, rather monthly. The person was progressively losing weight. This meant the service did not have a full overview of the person's health needs and when/if further professional input was required. We further found that no records had been kept of the food eaten by the person. Records written stated "lunch", "dinner" "food declined" "supper offered". Staff failed to accurately detail what was eaten, if anything and the amount. The person's file contained a choking risk assessment, which identified the person at risk, with advice stating, "cut foods up into small pieces". No other documentation made reference to a choking risk. Staff were unable to provide any insight into whether this risk was actual. By not having the knowledge required to provide appropriate support, staff were placing people at risk.

We found that as a result of failing to accurately record and monitor people's changing health needs, professional advice was not always sought appropriately. Where advice was required in the form of guidance from a speech and language therapist or a dietitian, this was not sought. Referrals to health professionals were similarly not made. For example, one person had been prescribed an 'as required' medicine for a condition and their care notes stated the person should be monitored and staff were to 'liaise with GP'. There was no evidence monitoring had taken place, nor of any further liaison with the GP. One person we spoke with told us, "I want to see a doctor because [the symptoms are] not normal for me. I keep asking, but they just tell me I am alright." The person's care plan stated they had seen the GP a month ago regarding a suspected infection, but there was no evidence of any further GP visits since. We spoke with the clinical lead, who was unaware the person had requested to see the GP. We asked the clinical lead whether they would share this concern in the daily handover meeting, and they told us, "If [person] tells the nurse, then yes." Handover meetings are where staff share key information at the start of one shift and the end of the previous shift. Changes in, and concerns regarding people's health and wellbeing needs should be shared at handover as a matter of course. The lack of monitoring of people's health needs put them at high risk, and identified the service's failing at keeping people safe.

The service remained in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff were unable to demonstrate the knowledge required to keep people safe. Records were insufficiently completed; care plans and risk assessments were conflicting and an inaccurate reflection of people.

Inadequate

Is the service well-led?

Our findings

At the last inspection of September and October 2018, the service was rated inadequate in this key question. At this inspection we found that little improvement had been made. The governance of the service remained inadequate.

We found that care plans and risk assessments were being signed off as having been reviewed and completed, when it was evident that this was not accurate. For example, we noted for several people that their Body Mass Index (BMI) was written as "0". This was reviewed multiple times, with the document reading "no change" each time and the same BMI written in subsequent months. Registered nurses completing both the initial document and the subsequent reviews failed to establish that a person cannot have a BMI of 0. We checked one person's weight in accordance to their height on the BMI chart, and found they scored 34. This put them in the "obese" category. The person was bedbound, and therefore having an accurate reflection of their BMI was crucial for skin integrity and how staff managed this person's hydration and moving and handling needs. The registered manager, who had completed monthly audits, had not picked up on these inaccuracies.

During the inspection we spoke with one person who repeatedly told us that they were left alone for long periods of time. They were not spoken with, nor engaged in any meaningful activities. Staff confirmed that the person remained in their bedroom at all times. Their age was cited as a reason for non-engagement in activities. We checked their care plan and found that whilst one stated they wished to be actively offered activities, another stated they wanted to remain in their room. The person, who had mental capacity, and was able to clearly articulate their needs felt that the home and staff had abandoned them. They stated the registered manager very rarely came to see them, and requested that we ask them to visit, as they wished to raise a number of concerns. We were told that they had requested a wheelchair so that they can attend activities in communal rooms, however staff had not arranged this. We spoke to the registered manager regarding this. We were told that a wheelchair had been tried, and the person found it uncomfortable and requested to return to bed. We queried when this was and on how many occasions, and were told once, during summer. This did not demonstrate that the staff were aware of the importance of allowing a person to be proactively involved in things, and that if a person declines once, this should not set a precedent.

In another file, we found that one person who was deemed to have high risk behaviours, (determined through multiple agency involvement), had a typed risk assessment written at the service which scored them as 8, medium risk of the behaviour. This was in contradiction to the multiple agency agreement. This risk assessment was further to be reviewed weekly. We found that although the risk assessment was written on 2 October 2018, no reviews had been completed. This accumulated to nine missed reviews. We brought this to the attention of two senior staff, one of whom was the author. Both acknowledged that a review was neither complete nor in the person's file. The record was taken by the clinical lead, to be discussed with the registered manager as it was believed that they may have been reviewing the person. One hour and thirty minutes later, a registered nurse brought the original document back stapled with an additional sheet. The medium score had been crossed out and replaced with a hand-written score of 15, placing the person as high risk. We raised concerns regarding the authenticity of the document. This was not the risk assessment

that had been taken. The registered nurse stated they had reviewed the risk assessment, and the now attached review sheet clearly illustrated this. We reiterated that the document that was within the person's file, and had left the room, was entirely typed. The score was 8 and not 15. Furthermore, whilst the additional document illustrated two reviews (monthly) had been completed, this was not in line with the requirements of the risk assessment, that clearly stated weekly reviews. The author of the document acknowledged that the returned document was not the same as the one that left the room. We raised serious concerns with the registered manager regarding inaccurate recording and changing of documentation retrospectively to meet requirements. This not only puts the person at risk, but also raises concerns about the professional practice of some staff. The registered manager was unaware that no reviews had been completed.

Similarly, this person had a care plan that was contradictory. The person was to be supported by male staff only. However, a newly developed document "Review of Needs" dated 4 October 2018 stated, "male carers is preference. Assistance of two carers i.e. 2 females, 2 males or 1 male and 1 female." Whereas the falls care plan dated 5 October 2018 read, "only trained male staff to transfer." This person's file was allegedly being reviewed monthly, and signed off as "no change" or "accurate". No one had picked up the discrepancies written within the documentation. This not only put the person at risk, but potentially staff also. This further raises concerns for the Care Quality Commission as this person's care records had previously been looked at the last inspection following which we were told that a thorough review of their needs had been completed. Our findings illustrated that if reviews had been done, these had not been effective. Conflicting and potentially unsafe assessments put everyone at risk. The governance of the service had failed to assess, monitor and improve the quality and safety of the care provided at the service.

We were informed during the inspection that 35 people's files had been rewritten. We rechecked whether they had been comprehensively audited or as was being suggested, rewritten. It was reconfirmed that these had been rewritten, by the registered manager, the peripatetic manager, in the presence of the compliance inspector and a clinical lead. The registered manager was unable to provide names during the inspection process, of people whose files were newly developed. As such we were unable to check these. We requested that we be provided with a list of the 35 names, so that this could be shared with the Local Authority for any future reviews they may be completing. On the 10 December 2018, we received an email containing a document that provided 35 names. Two of the names had been ticked. A footnote read, "All these care plans have been rearranged and audited, some care plans have been re-written and now are being audited by Compliance Inspector and Quality Manager." This document conflicts with the information that was provided during the inspection. Although we had sought clarity and therefore presented the provider with the opportunity to correct any misunderstandings, we were specifically told 35 files had been rewritten.

The management of the service, governance and understanding of regulations continue to be poor. The service remains in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.