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?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service: Moor View Care Home is a residential care home that was providing personal and nursing care to 15 people with mental health needs at the time of the inspection. The service is registered to care for 17 people.

People's experience of using this service:
People were not safe because risks had not been properly identified and mitigated.

Safeguarding processes were in place but incidents were not always recognised as safeguarding concerns, and therefore not reported appropriately.

People were not always consulted about matters affecting them and decisions were sometimes made on behalf of people, without seeking their consent.

Some staff knew people well and understood their personal preferences. However, care was not person centred and people had limited opportunities to work towards their goals and aspirations.

There was little evidence the provider had respect for people or regard for their dignity because the environment and furnishings were not clean or well maintained.

Care and support records were not efficient or effective enough for staff to locate information about people's care, risks and support needs.

People and staff told us the new manager was beginning to make a difference in the home.

Staff said they felt supported through training and supervision and they gave positive comments about the manager.

We found there was not enough robust oversight of the quality of the provision and there were three continued breaches in the regulations since the last inspection, with four new breaches identified.
Rating at last inspection:
At the last inspection the service was rated inadequate overall (Report published 8 November 2018)

The service had not improved sufficiently at this inspection and the rating remains inadequate.

Why we inspected: This inspection was based on the previous rating and our ongoing concerns about the quality of the care provided. At the last inspection there were three breaches identified. These were in Regulation 12 safe care and treatment; Regulation 13 safeguarding and Regulation 17 good governance. At this inspection, the three breaches continued and a further four breaches were identified. These were in Regulation 9 person centred care; Regulation 10 dignity and respect, Regulation 11 need for consent and

Regulation 15 Premises and equipment.

Enforcement: The service met the characteristics of Inadequate in all the key questions of safe, effective, caring, responsive and well led. We are taking enforcement action and will report on this when it is completed.

Follow up: We will continue to monitor the service closely and discuss ongoing concerns with the local authority.

The service remains in 'Special Measures' by CQC. The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

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.

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.

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. We will have contact with the provider following this report being published to discuss how they will make changes to ensure the service improves their rating to at least Good.

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

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.

Details are in our Safe findings below.

Is the service effective?

Inadequate

The service was not effective

Details are in our Effective findings below.

Is the service caring?

Inadequate

The service was not caring

Details are in our Caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Moor View

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by three adult social care inspectors.

Service and service type: Moor View is a care home which provides nursing and personal care to people who need support with mental health. At the time of the inspection the service was working towards a recovery and rehabilitation model of care. This meant they were aiming to support people to develop more independent living skills.

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. However, the registered manager had left the service and there was a new manager in post who told us they were in the process of registering with CQC.

The inspection was carried out on 25 April 2019 and was unannounced.

We reviewed all information about the service including information sent to us by the provider as well as liaison with stakeholders including the local authority. We had asked the provider to complete a Provider Information Return (PIR) prior to this inspection. The PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We looked at premises and equipment and documentation relating to the safety of these.
For example:
Notifications we received from the service

Completed CQC surveys from people who used the service
Four people's care records and three medicine records
Records of accidents, incidents and complaints
Audits and quality assurance reports
We spoke with four people using the service
Nine members of staff, including the management team, the cook and cleaning staff

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met. There has been no improvement to the rating of inadequate in this domain.

Systems and processes to safeguard people from the risk of abuse

- Safeguarding processes were in place and staff understood these. However, incidents were not always recognised as safeguarding concerns, and therefore not reported appropriately. For example, one person had had their mobile phone taken from them by a taxi driver, yet this was not regarded as a matter which needed reporting to safeguarding.
- One person was identified by the service as at risk of financial abuse, yet there were no details about the safeguarding measures in place.
- There was a continued breach in Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding people from abuse and improper treatment.

Assessing risk, safety monitoring and management

- People were not safe because risks had not been properly identified and mitigated. There were hazards within the environment which had not been addressed and meant there was a risk people could be hurt. For example, a broken ground floor window was opened out onto the garden and had been like that since February 2019. We asked the manager to ensure this was attended to with immediate effect, yet we discovered it had still not been made safe during the day of the inspection.
- Since the last inspection there had been a fire in the home and staff had followed all necessary fire procedures. However, there were no effective risk management strategies to ensure people were safe, such as when smoking. One person we spoke with told us they had felt very frightened at the time of the incident, and there was no evidence people who lived in the home had been offered any support or reassurance about fire safety.
- One fire evacuation plan on the wall directed people to a route with a recently blocked up doorway. The manager amended this as soon as we pointed it out, but we were concerned it had not been revised prior to the inspection and in light of the fire in the home.
- At the last inspection, risk assessments were not always clear or well organised in people's care plans. This had not sufficiently improved at this inspection. Some information about people's individual risks was contained within the care records, but this was not possible to extract in a way which showed staff what the risks were and how they should be mitigated. When we asked staff to locate information for us, they found this very time consuming to find and were not always able to show us.
- Some 'risk controls' sections within the care records were blank so it was not shown how people's safety was assured.

Staffing and recruitment

•□Staffing levels were adequate to meet people's physical care needs. However, people's skills in independence were not promoted because there were not always enough staff deployed to support them towards this in or outside the home. Staff said people were supported to go out, but only if there were sufficient staff to do so or if this was arranged in advance. This was a concern at the last inspection which had not been addressed. The manager told us they were in the process of recruiting a community link worker to support people.
•□People told us there were not always enough staff to meet their needs. One person said, "They've always got stuff to do." Staff we spoke with said there had been high levels of agency staff used, but they did not always understand people's needs and did not have access to information about people in care and support plans.
•□There was limited evidence people had been recruited robustly. For example, one staff member's record showed a discrepancy on their Disclosure and Barring Service (DBS) check, but there was no robust evidence this had been discussed or any potential risk to people assessed before they were employed. There was no evidence the member of staff had completed their induction. The manager showed us an email from the provider which indicated they had approved the appointment and were satisfied the recruitment process had been followed.

Using medicines safely
•□Medicines were not stored safely; there were three boxes of medicine unlocked in the medicines room. People's medicines were being stored in their own rooms at the start of the inspection, although at the end of the day one team manager told us they were all being moved into the medicines room due to the storage temperatures in people's rooms being too high. Records showed room temperatures were taken daily, but the thermometer in the medicines room was broken and the room felt warm so there was no assurance medicines would be stored at safe temperatures.
•□Medicines support plans for one person showed different information and it was not possible to establish the current information as one of the records was not dated.
•□One person's care plan listed the medicines they needed to take, although this was not up to date. The person's medicine administration record (MAR) showed there were two further medicines they should be taking, which they had been refusing. There was no information on the person's care plan to show the GP had been contacted with regard to them refusing these medicines.
•□The registered manager told us it was company policy for all people who were self- medicating to have a risk assessment for this, yet this was not in place for one person whose records we looked at.

Preventing and controlling infection
•□The environment was not sufficiently clean for people and we referred our concerns to the environmental health team following the inspection. For example, at least six individual bedrooms were visibly dirty and some rooms had strong unpleasant smells. People's ensuite bathrooms had dirty walls and tiles. We saw rusty shower chairs and a toilet seat which did not fit. There was a mattress stored in one person's ensuite bathroom.
•□One communal lounge had an offensive odour and there was a radiator which had a build up of saliva and mucous deposits. Staff told us this had been the same since at least December 2018 and nothing had been done to clean this area.
•□There were two domestic staff, one of whom said they found it difficult to carry out 'deep cleans' and tried to do this when they both worked at the same time.

Learning lessons when things go wrong
•□The manager told us they reviewed all accidents and incidents daily as well as notes from daily handovers

to check whether any matters needed to be reported. However, information we looked at did not show the manager had always reviewed these and there was no analysis carried out to identify any trends or patterns within the service.

• There was no evidence to show how lessons were identified when things went wrong in the service. Matters from the last inspection had not been sufficiently acted upon or addressed to ensure breaches were not repeated and we identified further concerns and breaches at this inspection.

• There was a continued breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment

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

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met. This domain was rated requires improvement at the last inspection and has deteriorated to inadequate.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; 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 with appropriate legal authority. 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. There was a lack of understanding about people's rights and we were given differing information regarding whether people were being deprived of their liberty. For example, one team manager said there were three people who had a DoLS in place and the manager said there may be one.
- Mental capacity assessments were not detailed or thorough and were not specific to each decision. For example one person's record stated they lacked capacity to make 'various decisions', but did not state which or how this had been assessed.
- There was no evidence of any consultation with people when the management team made decisions they deemed to be in the person's best interests. For example, where decisions had been made about people's spending or movements. One person's visitors had been asked not to come as the management team felt this was a safety precaution for the person, yet they had not given their agreement for this.
- There was little evidence people had choices in matters which affected their everyday lives. For example, the decision to move medicines from individual rooms had been made without asking people first.
- We concluded there was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Need for consent

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

- At the last inspection the premises were in need of refurbishment. At this inspection, we found some areas had been refurbished, for example kitchen areas had been adapted to enable people to use the facilities themselves, with or without support. However, many areas were very badly worn, with furnishings

and fixtures worn and in a poor state of repair.
•□Sofas in the main lounge were worn and damaged. The washing machine in the laundry room was not working, therefore people could not access this easily to independently do their laundry.
•□One person's room contained someone else's belongings and drawers and the room had not been prepared for the person using it. In other people's rooms we saw broken furniture, such as chests of drawers with fronts missing.
•□One person's shower in their ensuite had a note on it dated 23 January 2016 stating 'shower too hot, do not use until further notice'.
•□The conservatory contained one chair and the flooring was badly damaged. There were holes in walls and paint was peeling in some areas.
•□The small lounge in the four bedded unit contained miscellaneous items for storage and was not welcoming.
•□We concluded there was a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Premises and equipment

Staff support: induction, training, skills and experience
•□Staff felt as though they had sufficient training and supervision to support them in their role. The manager showed us a training matrix which identified which staff needed training and when. There was a supervision matrix which showed supervisions completed and scheduled, as well as an appraisal schedule.
•□There was a new clinical lead in post part time, who was available to provide clinical supervision to nursing staff.
•□The manager told us there was specific training scheduled for registered nurses and recovery workers were to be upskilled to enable them to support people more effectively. They said training was a combination of face to face and online and they showed us some evidence of recent away days and workshops.
•□There were no consistent competency checks of staff practice and the manager told us this was work in progress.

Supporting people to eat and drink enough to maintain a balanced diet
•□There was limited information within people's care records regarding nutritional risks and dietary needs.
•□The cook understood people's individual needs and worked with the staff to ensure meals were appropriately prepared and menus balanced.
•□The cook told us people had been supported to make their own pizza and had enjoyed this. Staff said one new person wanted to use their cooking skills to make a meal for other people and they were working to support the person to do this.
•□People were able to access their own drinks. One person said they enjoyed making their own cup of tea or could help themselves to cold drinks if they preferred. The main kitchen was not accessible to people and so staff brought snacks for them, such as crisps, on request.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
•□There was some evidence in people's care records they had appointments with other health professionals and staff told us they supported people to attend these. Staff said they alerted people's GP if there were any health concerns.
•□The manager told us some people were moving on to new places to live and these were planned moves. They showed us some evidence of working with the CCG and other providers to identify and plan when people would move on.

Inadequate

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

People were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls and some regulations were not met. This domain was rated good at the last inspection and has deteriorated to inadequate.

Supporting people to express their views and be involved in making decisions about their care
•There was little evidence people were involved in meaningful discussions or decisions about their care and support and there was no evidence of individual reviews or feedback.
•Staff told us there were 'working together' meetings in which people could choose as a group how they wanted to spend their time and a group timetable was produced from this with agreed activities. This was not person centred or individually reflective of people's choice.
•People were unable to make decisions about their daily care or be spontaneous in their choice of what to do because they relied on there being sufficient numbers of staff to facilitate their needs.
•One person had been admitted to hospital and prior to this there had been plans for them to move out of Moor View Care Home. The person was served notice whilst in hospital and there was only very limited information about how they had been consulted and involved in the decision making process, or what measures had been put in place to prepare for this event. Some care notes we reviewed showed the person objected to moving out and would have preferred to stay at Moor View.

Respecting and promoting people's privacy, dignity and independence
•There was little respect for people because the provider allowed their living accommodation to become in a poor state of décor and cleanliness. This meant people lived in undignified conditions.
•One person had a set of drawers in their room marked 'catheter care' and 'stoma care'; these had belonged not to the previous occupant of the room, but the one before that. There was no respect shown for any of the people who occupied this room and no care had been taken to ensure the room was prepared with regard for people's dignity.
•People were not supported to be as independent as possible. We saw little evidence of people involved in their own daily living tasks.
•Staff were respectful and polite when speaking with or about people.
•We concluded there was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Dignity and respect

Ensuring people are well treated and supported; respecting equality and diversity
•Staff had a kind and caring attitude and spoke with people in calm and friendly tones. When staff spoke about people they said they enjoyed working with them. One member of staff said, "I like to think I can make

a difference."

• The manager told us there were workshops for staff on inclusivity and diversity and said these had been interactive with staff attending.

• One person for whom English was not their first language, had some signs in their home language and staff had made some attempts to improve communication with the person. However, it was unclear how much effort had been made to support the person to practice their religion and meet their cultural needs. For example, the person had moved rooms and they had some religious artefacts which had not been moved, despite the person's relative agreeing for this to be done. It was unclear how much effort had been made to support the person to practice their religion and meet their cultural needs.

Inadequate

Is the service responsive?

Our findings

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

Services were not planned or delivered in ways that met people's needs. Some regulations were not met. This domain was rated requires improvement at the last inspection and has deteriorated to inadequate.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- At the last inspection, care was not personalised or planned around people's individual needs or interests. There had been no improvement at this inspection and we saw no evidence of person centred care or meaningful occupation.
- Staff knew people's interests and preferences, although there was not enough opportunity for them to support people in individual or purposeful ways in line with their needs.
- The manager told us they were working towards a rehabilitation and recovery model of care and as such, people had identified goals and aspirations. However, care and support records contained little evidence of people's goals or aspirations with no pathway identified to ensure positive outcomes.
- One person who was new to the service had some goals outlined, for example to regularly visit their own home and to travel on a bus. However, there was no clear evidence in their care record to show whether or how they were working towards this. The person's key worker said they had supported the person with this on occasion, but said it was not regular or consistent due to staff working patterns.
- Information in care and support records was conflicting, confusing and poorly worded. For example, one person's goal stated 'hair' but there was nothing to show what this meant.
- Staff we spoke with did not know what people's goals were and agency staff did not have access to the electronic care and support plans.
- People sat or walked around passively not engaged with activities or staff. The television was playing and nobody was watching. Some people were asleep on the sofa and some people just watched others. Some staff spent time chatting with people, but frequently staff stood up in the lounge areas in a supervisory role, rather than attempting interaction.
- One person's artwork was displayed on the wall and staff told us the person was a very talented artist. There was no information to show how this person's interests were being fostered and no evidence of resources they could use.
- Staff told us another person had experience of cooking and wanted to cook for others. They said the person had been supported to make a meal for people, although there was no information to show this was a regular feature of their support. Opportunities for day to day activities were not in place to enable people to practice skills in more independent living. This was at odds with the model of care the provider said they were aiming towards.
- One person told us, "We only get to go out if there's enough of them [staff] to go with" and another person said, "I'm not doing owt really, just sat about."
- There was an activity timetable on display and staff told us this was agreed at weekly 'working together meetings'; anything other than what was written in advance could not easily or spontaneously be arranged.

•□The manager told us one of the team managers coordinated people's moves and the support plans around this was work in progress. We saw a 'move on plan' for one person, but this did not show how they had been involved or helped to prepare for this major change to their life.
•□Care and support plans were unwieldy and information was not easy to access. Information was written in both the first and third person, reviews were not meaningful and there was little evidence of people being involved. Staff, including managers were also unable to find essential information to show how people's needs were planned for and risks mitigated. This had been a concern at the last inspection and had not been addressed.
•□We concluded the provider was in breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person centred care
•□Hospital passports were in place with key points of information should a person need to go to hospital.

End of life care and support
•□Care and support records did not contain sufficient information to ascertain whether people's end of life wishes had been discussed with them.
•□One person, who was receiving end of life support had no end of life care plan. Staff said this had not yet been discussed with the person.

Improving care quality in response to complaints or concerns
•□The manager said there had been no complaints received since the last inspection. The complaints process was displayed for people to see. People said they would tell the staff if they had any complaints. Staff said they would support people to raise any concerns if necessary.

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met. There has been no improvement to the rating of inadequate in this domain.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- Since the last inspection, not enough improvements had been made to ensure risks to people's care were identified, mitigated and managed properly. The last inspection identified some risks were not being monitored safely, but this inspection highlighted further risks and concerns.
- The provider had made changes to the management of the home which were still being embedded within the service. The manager had been in post for four months and was new to the service since the last inspection. There was a new clinical senior practitioner in post who was working to improve the quality of the care and support recording.
- Systems and processes were not thorough and the electronic recording was not efficient or effective in helping staff and managers locate information in a timely or methodical way. Staff and managers found it difficult to find and record information relating to people's care and support.
- Recording of information relating to safety of the premises had improved since the last inspection.
- The manager told us they were working to address the cultural issues within the home and they felt the current staff team were on board with the changes taking place within the service. They said although the cultural changes were not rapid, they were confident the service would improve.
- There was a lack of planning and promoting person-centred care and support for people and although the manager told us about work being done to improve the standard of care, we saw very little evidence of positive impact on people's lives.
- The manager told us they were passionate about person centred care, giving people choice and empowerment to lead fulfilling lives. However, we did not see any evidence to support this happening in the service.

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

- There were some audits being carried out, although these still lacked rigour and did not identify areas of concern highlighted by the inspection process, or sufficiently address breaches in regulations. For example, where were told people's care and support plans had been reviewed, there were gaps in recording picked up in the inspection process.
- The manager did not have sufficient oversight of the quality of care being delivered. For example, analysis

of accidents and incidents was done by the provider's quality assurance team and not in house, therefore the manager did not have first hand knowledge of trends or patterns which may affect people's day to day care. The manager told us 'reports could be run' to obtain the information from the computer system but this was not carried out routinely.

•□The management team worked together but there was a lack of clearly defined responsibilities. The manager told us daily walk rounds were carried out but not documented and they were looking to improve this. They told us staff carried out daily, weekly and monthly health and safety checks although there was little evidence of management oversight of this. The inspection highlighted many areas of concern in the environment which had not been identified by the provider.

•□Staff said they understood their responsibilities and who they were accountable to. They told us the new manager was making a difference and they felt improvements were being made. One member of staff said, "Things are getting better with this manager."

•□The manager was supported by senior managers from the organisation and there were regular quality assurance visits. The provider produced an action plan following the last inspection although there was insufficient progress towards addressing the areas of concern.

•□We concluded the provider was in continued breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

•□Surveys were not carried out and the manager told us these were planned to be done in the near future.

•□The manager told us they had reviewed how people were consulted and included in meetings, such as the 'working together' meeting. They told us the current system was not person centred and they were introducing a new format for this, although it was not yet in use.

•□The manager told us they recognised staff contribution and looked at ways to highlight performance. For example, they said they made sure staff were recognised by the organisation for their bravery in dealing with the emergency situation when a fire occurred in the home.

•□Staff told us they felt involved with the changes taking place in the service and said they were able to contribute ideas and views in discussions and meetings.

Working in partnership with others

•□The manager told us they were working closely with the local authority contracts team, the CCG and safeguarding teams to ensure people's care was suitable and appropriately planned.