Mavesyn Ridware Residential Home Limited

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Inspection report

Mavesyn Ridware House
Church Lane
Rugeley
Staffordshire
WS15 3RB

Tel: 01543490585

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10 November 2020

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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

About the service
Mavesyn Ridware Residential Home Limited is a care home providing personal care and accommodation to 11 people aged 65 and over at the time of the inspection, some of which were living with dementia, a physical disability or sensory impairment. The service can support up to 21 people in a single adapted building.

People's experience of using this service and what we found
Systems were not effective at identifying areas that needed improving in a timely manner. Risks were not always assessed, planned for and mitigated to keep people safe as assessments were not always personalised.

Systems were not sufficiently in place to safeguard people from abuse. Safeguarding's had been raised but the registered manager did not have systems to record and act upon these concerns.

The registered manager failed to ensure that people's care records were accurate and up to date. The registered manager and provider did not undertake audits of people's care records.

Systems were not in place to manage medicines safely. Medication audits had been completed, however, they failed to highlight issues that were found during the inspection.

The principles of the Mental Capacity Act 2005 (MCA) were not applied consistently. The registered manager had not always carried out mental capacity assessments for some people and there were not best interest decisions to support staff when providing care for people.

The provider did not have clear systems in place to ensure the home was clean. The home was unkempt, we found cobwebs on the ceilings, curtains and the pelmet.

There were enough staff to support the needs of people during the days of inspection.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 22 August 2019). The service remains rated requires improvement. This service has been rated requires improvement for the last four consecutive inspections. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Mavesyn ridware residential home limited on our website at www.cqc.org.uk.

Why we inspected
We received concerns from the local authority after they raised a number of safeguarding's which related to

the care people were receiving in the home.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed. We did not inspect effective, caring and responsive due to us wanting to limit ourselves and spend the least amount of time in the home as possible.

Follow up
We identified concerns at this inspection. We will therefore aim to re-inspect this service within the published time scale for services rated Inadequate. We will continue to monitor the service through the information we receive.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified three breaches. Regulation 11 had not ensured that care and treatment was provided with consent from the relevant person, furthermore, the provider had not followed the principles of the MCA. Regulation 12 the registered person failed to ensure risks relating to the safety, health and welfare of people using the service were assessed and managed safely and the registered person failed to ensure the proper and safe management of medicines. Regulation 17 the registered person had not established an effective system to enable them to assess, monitor and improve the quality and safety of the service provided.
Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Mavesyn Ridware Residential Home Limited

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by two inspectors.

Service and service type
Mavesyn Ridware is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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
We gave one hour's notice so we could clarify the service's COVID19 Personal Protective Equipment (PPE) practice for visiting professionals and identify persons who were shielding or COVID19 positive so we could respond accordingly.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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
Due to the national pandemic we completed a focused inspection therefore reducing the time we spent at the service. We spoke with two people who used the service. We spoke with the acting deputy manager, four staff members and one visiting professional. During our time at the home we observed staff interactions with people. We looked at records relating to wound care management, risk assessments, care plans and accidents and incidents. We requested further information after our visit, this included risk assessments and care plans.

After the inspection
We continued to seek clarification from the provider to validate evidence found and we spoke with two relatives.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

● We found that risks to people were not managed in a safe way. Staff knew people well but hadn't received updated guidance on how to support people's individual risks and needs so there was a risk they would be cared for incorrectly.

●For example, one person's bowel chart evidenced they didn't have a recorded bowel movement for eight days. We were told staff would document this for this person. There was no escalation guidance to advise staff what to do if there were concerns identified. We were told they supported this person by giving extra prunes on their breakfast, however no additional guidance had been gained for support from other health professionals. This placed people at risk of prolonged discomfort and not receiving the correct medical support.

● The same person's care plan was inconsistent, it stated they were to use specialist equipment to keep them safe but later on in the care file it said this was too small and not to use this. We asked the deputy manager, who told use that they thought it was because equipment was too old, and they only used the equipment when mobilising. The registered manager rewrote this person's care plan to say not to use the equipment and not to walk this person using a frame. However, it was unclear who they had received this guidance from and what was the correct information. In addition, to help them further, this person should have had their feet elevated, however we found this was not taking place and highlighted this on the first day of our inspection. This feedback had not been acted upon by the end of the day.

● On the second day of our inspection staff continued to support the same person incorrectly in relation to the equipment. This person was at risk of receiving inconsistent support that did not meet their care needs.

● People did not always have their risks assessed. There was no clear process to manage risks , or to make sure people were involved in decisions about how their risks were to be managed. For example, for one person whose needs had changed, where they required a hoist, there was no risk assessment in place to advise staff on methods of moving them.

● The registered manager did not act when they had been provided with information about people's health conditions. One person had had a health condition diagnosed prior to them moving to Mavesyn Ridware and had resided in the home for a number of months. The deputy manager told us it was observed their arms would shake when standing using a frame, but they put this down to anxiety. There was no information in the care file on how best to support the person or referral to a professional for advice in relation to this condition. When we spoke to the registered manager later, they told us they were not aware of this. The person was placed at risk as staff were not aware of how to support their health condition.

● Another person who was to be supported with their oral hygiene did not always have their records kept up to date to evidence this had taken place. We found gaps in their records and these had not been completed since September 2020. We could not be assured this person was being supported to meet their oral health

needs correctly.
● There was no clear process to manage risks appropriately. For example, one person had four recorded incidents in 2020 in relation to their behaviours but did not have their risk assessment updated following these incidents to reflect what could be done to help staff manage these.
● The registered manager completed a monthly analysis of all incidents. However, we found that not all incidents had been recorded for this month. Therefore, we could not be assured the analysis was meaningful and the registered manager could use this learning to prevent reoccurrence. .

The registered person failed to ensure risks relating to the safety, health and welfare of people using the service were assessed and managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Using medicines safely
● Medicines were not always managed safely.
● There was limited guidance for staff to assist them in administering covert medicines safely. Covert medicine is medicine which is 'hidden', usually in food or drinks. Care plans did not indicate what measures should be tried prior to resorting to giving medicines covertly and there was no guidance in care plans about how the covert medicine should be given.
● One person who was given their medicines covertly did not have a medication risk assessment in place to guide staff on any risks or escalation processes to take if the person refused their medication. We requested this information following our inspection, however the registered manager did not provide this.
● It was not clear if people had received their topical creams as prescribed. Staff had not always signed the associated topical creams records to say this had been given and reasons were not documented to explain why this medicine was not signed for.
● One person's medication risk assessment was completed in September 2012; however, we found no evidence that a review had taken place. When we asked the registered manager they told us, they thought it was the role of the community psychiatric nurse to review.

The registered person failed to protect people from the risks associated with the unsafe management of medicines. The registered person failed to ensure risks relating to the safety, health and welfare of people using the service were assessed and managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

● Staff supported people to take their medicines in a respectful way. Staff ensured people's dignity was maintained when administering medication.

Systems and processes to safeguard people from the risk of abuse
● People and relatives told us they felt people were safe in the service. One person told us, "Yes staff are very good if I need anything, I feel safe, I'd say 100/100."
● However, effective systems were not in place to safeguard people from harm and abuse. The registered manager did not have a system in place to evidence safeguarding referrals had been raised when there were concerns about potential abuse or that investigations had taken place.
● In the previous week, the provider had three safeguarding concerns raised by professionals about the care they were providing, however there was no evidence the registered manager had logged these or was investigating them in any way.
● Not all staff had completed their annual training in relation to safeguarding vulnerable adults. The providers training matrix highlighted 17 staff had not received or updated their safeguarding refresher training.

● However, staff told us they knew how to report a safeguarding concern and could give a full explanation of what constituted a safeguarding incident. One staff member told us, "Not meeting the duty of care," and a second staff member told us, "If there was something wrong with one of the residents."

Preventing and controlling infection

● We were told that the service did not have designated domestic staff and care staff would assist with the cleaning of the home.

● On the first day of inspection the dining room was undergoing redecoration. However, we found cobwebs on the ceilings, curtains and the pelmet.

● There was an uncovered fuse board at the bottom of the front stair case, that had not been securely boxed off. Some people at the service were living with dementia and were mobile so there was a risk that these people could be harmed from touching this.

● We found that new PPE (personal protective equipment), gowns and gloves, were being stored on handrails along corridors. The registered manager did not have any audits in place to evidence how often these handrails had been cleaned therefore the PPE was at risk of becoming contaminated by people touching the handrail. .

● 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.

Staffing and recruitment

● We found that people were supported by a sufficient number of staff. People told us staff responded to them promptly when they required support.

● Required staff recruitment checks including criminal checks with the Disclosure and Barring Service were carried out to ensure people were protected from being supported by unsuitable staff.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to have effective governance systems and processes in place to prevent abuse of service users. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found there had not been enough improvement and the provider was still in breach of regulation 17. This was the third time the provider had been in breach of this regulation.

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

- There were limited quality assurance processes in place. There was no oversight from the provider, they did not monitor that checks or audits had been undertaken or completed in the service. We were unsure how the provider was supporting the registered manager in their role.
- There was no evidence that care file audits had taken place. When giving initial feedback to the registered manager, they told us, "I do do them, but with everything that has been going on, not so often."
- Audits had not identified incomplete documentation. An end of life care plan for one person had one word written on it and then was signed by the registered manager but not dated. The lack of audits had failed to identify that documentation did not always provide staff with the necessary information.
- The medication quality assurance processes in place were not effective. They failed to identify topical medicines were not always being recorded by staff as administered and one medicine risk assessment had not been reviewed for eight years.
- Ineffective quality assurance systems meant that the provider could not always continuously learn, improve and innovate. There was not a system for them to identify any common themes or risks developing for people in the service to help prevent reoccurrence.
- Systems to monitor staff practice and competency were not undertaken currently and there was no evidence of training certificates to show what training staff had completed. The registered manager told us, "We have struggled to keep training up to date due to the pandemic."
- The registered manager had no clear system or processes in place to evidence safeguarding concerns or investigations had taken place.
- The registered manager did not have any infection prevention control audits in place or heightened cleaning schedules to evidence that frequent 'touch points' had been cleaned frequently throughout the day during the pandemic. This increased the risk of the spread of infections.
- The providers last rating was not displayed in the service. It is a requirement that the provider displays their last inspection rating at their registered premises. The registered manager told us, "Our CQC ratings

was in the rack on the shelf in the foyer. We have now placed it in a more appropriate place where it can be seen."

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had not established an effective system to enable them to ensure compliance with their legal obligations and the regulations. The registered person had not established an effective system to enable them to assess, monitor and improve the quality and safety of the service provided.

● At this inspection the registered manager had not ensured the service was working within the principles of the Mental Capacity Act (2005) to safeguard people from abuse. For example, we found where people lacked capacity and best interest decisions had been made, there was no evidence that professionals or family members had been involved in these. People were at risk of having decisions made for them unlawfully.
● We requested further information from the provider following the inspection. The provider sent us a copy of a person's mental capacity assessment they had recently completed. The assessment was completed on a plain piece of paper with only four answers on it and none of these related to why the capacity assessment was carried out. The assessment did not highlight if the person did or did not have capacity and was signed by the provider. It was not clear what the form evidenced or what support measures they were putting into place to support people in relation to their decision making.

The provider had not ensured that care and treatment was provided with consent from the relevant person, furthermore, the provider had not followed the principles of the MCA. This is a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● There was a clearly defined management structure within the service. However, there were not effective management systems to promote person-centred care. We found that care plans were not specific to people's needs. On both days of the inspection the registered manager was not able to be present in the home, and the acting deputy manager assisted us with any questions. They did not receive any support from the provider during the inspection process.
● The registered manager stated they understood duty of candour by telling us, "Our home is transparent, we have nothing to hide, anyone at any time can ask anything of myself or my staff. My staff know they can come to me about anything without any fear of any comebacks."
● We received a mixed review from staff regarding the support they received from the registered manager. One staff member told us, "The [registered manager] is approachable, but it's whether she does anything about what you go to her for. If you say something about somebody, they will say 'I'm not on the floor, so I don't know'. I feel sometimes they are not worthwhile here. They don't keep up with the paperwork."
● However, other staff felt the registered manager was approachable and told us, "Yes I feel concerns are acted upon and they are fair and approachable."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There was mixed feedback from relatives regarding the feedback that they had received from the service during the pandemic. One relative told us, "They have called with updates. Staff have additionally helped [relative] to call us on face time calls. If anything has changed, they call and let us know." However, another relative told us, "We aren't sure whether [relative] gets the messages we leave for him. We don't get a lot of information from them. We would like more information."

● The register manager had evidence of feedback from people. This did not have any set questions or themes. There was no action plan to support the feedback they received.
● The registered manager held staff meetings where staff could raise issues and information could be shared.

Working in partnership with others
● The provider had been supported by the local authority for the previous 12 to 18 months because of concerns that they had received. A number of safeguarding's and concerns regarding documentation were raised with the provider. However, they had failed to action any recommendations or put in appropriate support systems.
● On the day of inspection, we observed that professionals were coming to the service to support people's needs.

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 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that care and treatment was provided with consent from the relevant person, furthermore, the provider had not followed the principles of the MCA. This is a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person failed to ensure risks relating to the safety, health and welfare of people using the service were assessed and managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and The registered person failed to protect people from the risks associated with the unsafe management of medicines. The registered person failed to ensure risks relating to the safety, health and welfare of people using the service were assessed and managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

The enforcement action we took:

We imposed positive conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not established an effective system to enable them to ensure compliance with their legal obligations and the regulations. The registered person had not established an effective system to enable them to assess, monitor and improve the quality and safety of the service provided.

The enforcement action we took:

We imposed positive conditions on the provider's registration.