Rhodsac Community Living Ltd

Manswick Care Home

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 well-led?	**Inadequate**

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Manswick Care Home is a residential care home for people with learning disabilities and/ or autism, providing personal care to up to four people in one adapted building. At the time of the inspection there were three people using the service.

People's experience of using this service and what we found

Right Support
People were at risk of and had experienced abuse from others because staff did not know how to protect people from poor care and abuse. We saw recorded incidents between people where one person verbally abused another. The registered manager and staff had not reported this to the local authority safeguarding team and had not notified CQC.

Staff did everything they could to avoid restraining people, however staff had not always completed appropriate records when they restrained people. At times, staff used an unauthorised method to control the movement of one person. The registered manager and staff had not always learned from those incidents and how they could be avoided or reduced in the future. The registered manager had not reviewed recorded incidents. This meant support plans and risk assessments were not always up to date to reflect recent incidents.

People had plans for when they experienced periods of distress, however we found support plans had disorganised information, often this information was repeated in other support plans. This meant that important information about risks to people, staff or others was not always clearly recorded and there was a risk it could be missed.

Governance systems and processes were ineffective. Improvements had not been made since our last inspection. Some improvements had been made to the management of medicines; however further improvements were needed.

People were supported in a safe, clean, well equipped, well-furnished and well-maintained environment that met their sensory and physical needs. People had a choice about their living environment and were able to personalise their rooms.

Staff supported people to take part in activities and pursue their interests. Staff supported people to play an active role in maintaining their own health and wellbeing.

Right Care
Staff had not always fully understood the complexity of people's needs and associated risks. We saw some interactions between staff and one person which were not appropriate.

People's care, treatment and support plans had not always reflected their range of needs in clear and transparent ways.

People were supported to have maximum choice and control of their lives and staff, however the policies and systems in the service did not support this practice because appropriate assessments and best interest were not always completed.

Staff protected and respected people's privacy and dignity. People could take part in activities and pursue interests that were tailored to them. Staff offered people opportunities to try new activities that enhanced their lives.

People could communicate with staff and understand information given to them because staff supported them consistently and understood their individual communication needs.

Right culture
People were not always supported by management and staff who fully understood the holistic needs of supporting people with a learning disability and autism.
People told us they received good quality care, support and treatment because staff could meet their needs and wishes.

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 25 October 2021).
At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 23 September 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe, effective and well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Manswick Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to person centred care, assessing the risk, safeguarding, need for consent, staffing and governance.

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

Follow up
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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Manswick Care Home

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 Health and Social Care Act 2008.

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

Inspection team
The inspection was carried out by one inspector and a specialist nurse advisor.

Service and service type
Manswick Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Manswick Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection

Registered Manager
The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before 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. Sine our last inspection the provider was not asked complete the required Provider Information Return (PIR). This is information providers are

required to send us annually with key information about the service, what it does well and improvements they plan to make.

During the inspection
We spoke with three people who used the service about their experience of the care provided.
We spoke with five members of staff including the support workers, team leader and registered manager.
We spent time observing people to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included three people's care records and three medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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; Using medicines safely

At our last inspection the provider had failed to demonstrate safety was effectively managed and they had failed to ensure the proper and safe management of medicines. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Robust risk assessments were not always in place to ensure people, staff and others were kept safe. People's known risks were not always assessed, and control measures were not implemented to provide staff with clear guidance on how to reduce these risks. For example, some people could express their emotional distress towards others whilst they attended various activities in the local community, such as bingo, drama group or other social events. There were no specific risk assessments to mitigate these risks. The lack of effective strategies to support these people left them and others at risk of harm.
● Where risks assessments were in place these were not clear or coordinated. Risk assessments were disorganised and not easy to follow, which made it difficult for staff to determine all risks and control measures to reduce them. Often, the same information was repeated in risk assessments not necessarily corresponding to that specific risk. This meant people, staff and others were not appropriately protected to prevent potential harm.
● At our previous inspection we identified that systems for monitoring incidents was not always effective. At this inspection we looked at incident records and found these were now appropriately recorded. However, when incidents occurred, they were not reviewed to identify actions needed to reduce the risk of reoccurrence. Where risks assessments were in place, these had not been updated to reflect these incidents. For example, we looked at one incident where one person told staff they were going to hurt themselves after they had consumed alcohol. When we looked at this person's risk assessments, we found the risk of them hurting themselves was not identified and there were no control measures to guide staff on how to reduce this risk.
● Some improvements had been made to the management of people's medicines; nevertheless, further improvements were needed.
● Following our last inspection, medicines had been moved to more secure storage. Staff had monitored the temperature of the medicine area, however we noticed that on some occasions the recorded temperature exceeded the recommended safe storage temperature. Medicines should not be stored above a certain

temperature because it can physically change the medicine and affect their potency (how well they work), which can be harmful to people's health.
● When people required 'when required' medicines, often called PRN medicines, they had a PRN protocol in place to inform staff when the medicine should be given. We found that some PRN protocols required more detailed information. For example, a description of the person's appearance or body language which would suggest they would benefit from PRN medicine to help them.
● We looked at medicine administration record sheets and found some transcribed records did not include all of the required information. Such as the dose of the medicine. Additionally, some handwritten entries on people's medicine administration records were not always signed by two staff members.

The provider had failed to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had made some improvements to the environment to improve people's safety following our last inspection. For example, processes had been introduced for checking window restrictors and hot water temperatures.
● Staff who were responsible for the administration of medicines completed appropriate training, and had their competencies assessed in line with the provider's medicine management policy.

Systems and processes to safeguard people from the risk of abuse
● People were not kept safe from avoidable harm because staff had not always recognised and reported safeguarding incidents. Staff had training on how to recognise and report abuse, however this was not applied in practice. The registered manager and staff had showed limited awareness around recognising safeguarding concerns.
● We saw five recorded incidents between people where one person was verbally aggressive towards another. The registered manager and staff had not reported this to the local authority safeguarding team, had not notified CQC or carried out an investigation.
● The registered manager and staff had not always recorded the use of restrictions on people's freedom. The registered manager was not fully aware what restrictive practices were in place at the service. For example, staff told us they used a 'restraint belt' to control the movement of one person, however it was not used frequently. We found no corresponding care plan, risk assessment or any other form of agreement to use this equipment. This was not in line with current good practice as providers need to ensure restrictive practices are only used when necessary, are proportionate to the risk of harm and used as a last resort.

Robust arrangements were not in place to safeguard people from the risk of abuse. This was a breach of Regulation 13 (Safeguarding from abuse) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they felt safe living at the service.

Staffing and recruitment
● Safe recruitment was not always evidenced. We looked at four staff files and we found prospective staff's full employment history had not always been obtained or their reasons for leaving previous employment explored with them. Other pre-employment checks, such as Disclosure and Barring Service (DBS) checks and references from previous employment, had been completed. DBS checks let employers know applicants' criminal history to help them make safer recruitment decisions.
● People told us they received their required staff support and that staff were available to support them to

access various activities and places of interest.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The provider was facilitating visits for people living in the home in accordance with the latest government guidance.

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.

At the last inspection this key question was rated as required improvements. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

At our last inspection we recommended that the provider review their processes for reviewing people's care plans to ensure all necessary background information about people was captured. The provider had made some improvements, however further improvements were required.

- People's care and support plans were not always holistic, strengths-based, and did not reflect their needs and aspirations. Many care records contained extensive information about people and their needs, however the information did not contain detailed and up to date information about these needs and how they should be managed.
- One person had over 30 different support plans, this included five different support plans about their expressions of emotional distress. The same person had another four support plans about accessing the community. The information recorded across these support plans was repetitive, unclear and complex. Lack of clear and concise guidance increased the risk of people not receiving consistent support when they were experiencing distress.
- Another person had three different support plans, which were based on uninformed decisions and referred to three different therapies that, according to the plans, should have been offered to the person to help them when they were distressed. There was no evidence to neither confirm this person required these therapies, nor that they had been referred to or had any professional involvement with these therapies. Only a specially trained professional should deliver these therapies and staff at Manswick Care Home were not trained to support people with these therapies.
- We noticed some inappropriate terminology and statements used within people's support plans. For example, in one person's care plan we read that "some diets can have triggered autism", that the above-mentioned therapies "can treat autism" or the "[person] is nursed in the house".
- People did not have support plans about their goals and aspirations to promote their independence. Support plans did not include strategies to enhance people's independence and did not demonstrate evidence of planning and consideration of the longer-term aspirations of each person.
- People's support plans were not reviewed and evaluated in a meaningful way. For example, sentences from support plans were copied into the review section without further clarification or adjustment and some information was copied and pasted from previous months' reviews. This meant that holistic and comprehensive reviews to look for any changes to people's levels of distress, presentation or deterioration in mental health were not completed or acted upon.

The systems for ensuring assessments and care plans were accurate and reflected people's needs were not effective. This placed people at risk of harm. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Support plans around people's likes, dislikes, hobbies and interests were well written and were person centred.
● Some nationally recognisable tools, such as Malnutrition Universal Screening Tool (MUST), were used to monitor people's weight.

Staff support: induction, training, skills and experience
● Although the provider's training matrix showed staff had recently undertaken e-learning training in various subjects, they lacked the experience, knowledge and understanding of people's needs and how to manage these needs safely and appropriately.
●The provider did not have an effective system to check regular and agency staff's competency to ensure they fully understood and applied their training, best practice and followed people's support plans. Staff supervision records were not detailed and did not focus on staff professional development, knowledge and best practice.
● Staff had not always fully understood the complexity of people's needs and associated risks. During our observations we saw inappropriate interactions between one staff and one person. We saw staff had not followed their training and person's support plan. This increased the risks of this person not receiving consistent support and could lead to further escalations because staff did not recognise the risks and did not act upon them.
● When staff used restrictive practices to keep people and others safe, the provider had not held debriefing meetings with staff to reflect on their practice or to consider future improvements. We looked at records of incidents when people became distressed or anxious which resulted in staff sustaining physical injuries. There was no evidence to show staff had received any formal debrief or had been offered any additional support from the provider to discuss what had happened, what could be done better next time and whether any additional training was required.

Providers systems for ensuring staff had the training, support and experience to competently undertake their role were not effective. This placed people at risk of harm. This was further evidence of a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

● However, staff told us they felt supported by the provider and management team. One member of staff told us, "[The registered manager] is supportive, very understanding. She is here every day."

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 when this is in their best interests and legally authorised under the MCA. 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Some people who lived at the service were being deprived of their liberty, however, the provider was not always working within the principles of the MCA.
● As highlighted in the safe section of this report, some people living at the home were subject to restrictions upon their rights. Restrictive practices are when people are prevented from doing something usually in the form of restraint in order to keep them safe. Information was not always available in people's records to explain why restrictions were in place.
● Where people lacked capacity to consent, mental capacity assessments had not always been completed for specific decisions. For example, the assessment for one person did not describe what information had been provided to them prior to the assessment to help them understand what decision was being made. Another person was deemed to lack capacity to manage their own finances. We were unable to find the associated mental capacity assessment or any records of best interest decision-making.

The provider failed to ensure people's capacity was assessed in line with the Mental Capacity Act 2005. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

● The registered manager had submitted DoLS applications where people were being deprived of their liberty, however not all restrictions were always identified. When DoLS were authorised, the conditions on authorisation were met.

Adapting service, design, decoration to meet people's needs
● People lived in a clean and well-furnished environment. However, the garden area required some maintenance. We saw fence support posts were in poor condition with screws protruding from the fence panels. This put people at risk of injury.
● People's bedrooms were spacious and clean. People were able to decorate and personalise their bedrooms. The design, layout and furnishings in people's rooms supported their individual needs.

Supporting people to live healthier lives, access healthcare services and support
● People were supported to attend annual health checks, screening and to access primary care services.
● The outcomes of appointments and interactions with health care professionals was recorded in people's care plans, along with any advice given, to assist staff to support people appropriately. Staff and management liaised appropriately with healthcare professionals, such as GPs, to ensure people's health needs were met.
● People were referred to appropriate healthcare professionals to support their wellbeing and help them to live healthy lives. For example, one person told us they were trying to lose weight and they had been referred to attend a fitness group to help them exercise.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us they enjoyed the food and were offered choices.
● People were supported to maintain a balanced diet. Menus reflected what was being offered.
● Mealtimes were flexible to meet people's needs and to avoid them having to rush their meals.
● Staff supported people to be involved in preparing and cooking their own meals. We observed staff supporting one person to do this in the kitchen.

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.

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

At our last inspection we found there was a lack of oversight at the service to ensure effective governance. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Following the last inspection, the registered manager sent us an action plan to tell us what actions they would take to improve the safety for the people and governance of the service. At this inspection, we found some actions had been completed, however the providers system for governance had not been effective in making improvements and identifying the issues we found during this inspection.
● People were at risk because the provider had not acted promptly to ensure they had enough oversight of the service and the management team. The provider had failed to identify shortfalls and breaches of regulation in relation to risk management, medicines, safeguarding concerns, staff training, assessments, mental capacity, duty of candour and records.
● There was a lack of robust governance processes and systems to help ensure the safe running of the service. We were not assured the management team had the skills, knowledge or experience to perform their role effectively and safely. There was a lack of understanding of people's needs and oversight of staff practice. The registered manager told us they felt they were not given enough support from the provider.

Continuous learning and improving care
● The provider failed to operate effective systems to manage risk. From our observations, review of incident reports and from information provided by the management team and staff we identified safety concerns and safeguarding incidents had occurred. These placed people and staff at risk of harm. However, safeguarding incidents and concerns had not been investigated, analysed or acted upon effectively to inform ongoing practice and ensure people's safety.
● Where external agencies had carried out audits and quality checks, work in ensuring the necessary improvements were addressed had not been fully completed. For example, the Local Authority quality monitoring team carried out a quality check visit in April 2022 and made some recommendations. We found not all those recommendations had been completed or implemented.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open

and honest with people when something goes wrong
● The provider had not always acted in line with their duty of candour. Relevant professionals and stakeholders were not always informed about certain serious incidents that took place at Manswick Care Home.
● CQC had not always been informed of incidents and events at the service which the registered manager and provider are required to notify us off. This is so we can be assured that events and incidents have been appropriately reported and managed.

The provider failed to monitor and mitigate risks and manage the quality of the service and for individual people using the service. This was a breach of Regulation 17 (Good governance) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had sought additional support from an external consultancy provider to help them identify issues and to create an improvement plan.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People told us they had allocated key workers. A key worker is a named member of staff who is a key point for the person and their relatives, who ensures that person's needs, choices and wishes are not overlooked. People told us they had regular 'key worker' meetings during which they discussed issues, concerns or planned their activities. All the people we spoke with, told us they felt supported by the current staff team.
● All people we spoke with told us they were happy living at the service. One person told us they had improved some of their living skills because they were involved in many activities and tasks around the house.
● All staff we spoke with spoke positively about the registered manager and the service. Comment's included, "[Registered manager] is 100% supportive", and "This is a good place to work, we work as a team, everyone gets on really well."

Working in partnership with others
● There was some evidence that health professionals were involved with people's care. For example, people's GPs.

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 failed to ensure people's capacity was assessed in line with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure robust arrangement to safeguard people from the risk of abuse.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to demonstrate care and treatment is personalised specifically for the people using the service.

The enforcement action we took:

We issued a Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider's failed to assess and manage risks placing people, staff and other at risk of avoidable harm

The enforcement action we took:

We issued a Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure systems for monitoring the quality of the service were robust and in place. This placed people at risk of harm

The enforcement action we took:

We issued a Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff lacked competency and support in order to meet peoples' needs and assess and mitigate known risks to people.

The enforcement action we took:

We issued a Warning Notice.