Runwood Homes Limited

Maun View

Inspection report

261 Chesterfield Road South
Mansfield
Nottinghamshire
NG19 7EL

Tel: 01623423125
Website: www.runwoodhomes.co.uk

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11 July 2019
17 July 2019
25 July 2019
30 July 2019

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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
Maun View is a nursing home and accommodates up to 77 people in one building over two floors. Throughout our inspection 72 people were using the service. People had either nursing or residential care needs and many of the people were living with dementia. The home was separated into four units, three of which were for residential care and one was just for those who required nursing.

People's experience of using this service and what we found
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Medicines were not managed effectively. People were at risk of not having medicines administered as prescribed. The management of medicine in the nursing unit was not safe or effective. The provider was relying on agency nurses who did not know people living at the home. Care plans and risk assessments were not sufficiently robust or detailed to give relevant information on people's care and any potential risks.

The provider failed to put robust systems in place to monitor and manage risk. Care plans were being developed electronically but did not have enough information in all areas of care needed. Risk assessments did not consider all risk or ways that risk could be mitigated.

Incident and accident reporting was poor and there was no analysis to inform better outcomes and reduce the likelihood of the event reoccurring. There was no management oversight leading to poor recording and no information on when concerns needed to be referred to healthcare professionals.

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 May 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made but the provider remained in breach of Regulation 12 (Safe Care and Treatment) and Regulation 17 (Good Governance). Insufficient progress had been made towards the improvement needed. We also found breaches in Regulation 11(Need for Consent) and a breach of the Care Quality Commission (Registration) Regulation 18 (Failure to Notify).

Why we inspected
Prior to the inspection we also received concerns in relation to the management of medicines, insufficient staffing, infection control and care planning. As a result, we undertook a focused, responsive inspection to review the Key Questions of Safe and Well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other Key Questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.
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 improvement. Please see the safe and well-led sections of this report. The provider has taken some action to mitigate the risk but progress has not been efficient and therefore risk has not been reduced sufficiently.

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

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

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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our reinspection programme. If we receive anything concerning, we may inspect sooner.

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.

Maun 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. 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 took place over four days. On 11 July 2019 there was one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the 17 July 2019 two inspectors carried out the inspection. On 25 July two inspectors and a nurse from the Clinical Commissioning Group (CCG)carried out the inspection. On 30 July two inspectors and a nurse from the CCG returned to carry out the inspection.

Maun View 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 did not have a manager registered with the Care Quality Commission.

Notice of inspection
This inspection was unannounced.

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. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with 18 people who used the service and four relatives about their experience of the care provided. We spoke with 17 members of staff including the regional director, manager, assistant manager, clinical lead, maintenance, head housekeeper and three care assistants. We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at three 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.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service. Professionals from the CCG and the Local Authority continue to support and monitor the service.

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. The provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection this key question has now deteriorated to inadequate. The provider has failed to make improvements since the last inspection and continues to put people at risk.

This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

● Staffing levels were insufficient to meet people's needs and keep them safe. One nurse was dismissed for poor practise at the time of our inspection. This meant that the only qualified nurse directly employed by the service was the clinical lead.

● Agency nurses were bought in to cover the nursing unit. The agency nurses were not familiar with the home and concentrated on giving people their medicines and not the wider role required in nursing care. At our visit on 25 July 2019 we found that none of the staff working on the nursing unit knew the needs of the people placing them at risk of harm

● We saw examples where people had to wait a considerable length of time to have their needs met. One person told us, "It can be up to half an hour, it's the same at night time.'' A relative told us "I asked at a relatives' meeting if staffing had reduced as people were beginning to look scruffy. I was told that staffing had increased.''

● One staff member told us, "I don't think there is enough staffing to cover holidays and sickness.'' Another staff member told us that they had previous experience in care. They told us that there had been no induction and when they had worked on the nursing unit a person asked for a drink. The staff said ''I daren't give [named] anything in case she needed her drink thickening, it turned out that she did.'' This poses a risk to people who have swallowing problems if they were given un-thickened fluids by untrained staff.

● Robust recruitment processes were followed to ensure that people were protected from unsuitable staff. This included checks on staff employment history, DBS and identity.

Using medicines safely

● Peoples prescribed medicines were not ordered, stored, administered, disposed of and managed consistently. Best practise guidance and the provider's medicines policy and procedure were not followed. The policy was not robust enough for the checking in and disposal of medicine.

● During our visit we spoke to a health professional from the CCG who were supporting the home with the management of medicines. There were concerns over the ordering and disposal of medicines and they were being supported with changing pharmacy. They were also supporting with medicines management overall.

● One person was prescribed medicine for seizures. This had not been ordered resulting in the person not receiving it for three days. The medicine information stated that if the medicine is stopped abruptly, it could cause a stroke.

● There were protocols in place for medicines which were taken 'when required' such as pain relief. However, these were not robust enough and did not highlight how they would know when people needed them if a person was unable to ask.
● Medicine which was not stored in blister packs should be dated and signed when the packet or bottle is opened. We observed that this was not happening. There were antibiotics stored in the fridge and were not dated or signed so we could not establish if they were in date or not. At our visit on 25 July 2019 we found that the fridge was found to be too cold for the storage of medicines, but this had not been addressed as a matter of urgency. This posed a risk to the medication being safe to take when not stored at the correct temperature.
● People were at risk of not having their medicine administered safely. The clinical lead told us that they gave two people their medicine covertly which means medicine being given in food or drink. There were no protocols in place and no information on how to do this from either the pharmacy or GP. It was also unknown if it was safe to take in certain food types deeming them ineffective.

Learning lessons when things go wrong
● There was no mechanism to obtain opinions or feedback from residents, relatives or visiting professionals. There were no regular meetings to share opinion or give information to relatives or residents. The clinical lead told us that a meeting had taken place the week before our inspection and that they had started to take notes and had to leave. No further notes were taken which means that there is no record of the meeting.
● Incident and accident reporting were poor and there was no follow through or oversight by the manager. The incident forms lacked information and contained no body maps to see at a glance where the injury had occurred. Where incidents reoccurred, there was no evidence of learning or review to enable similar incidents happening again.

Preventing and controlling infection
●. In the medicine room there were holes to the side of a cupboard and exposed chipboard on the counter top. In one of the unit's the kitchen floor was dirty, and the flooring had come away from the skirting board which was stained. The floor should be sealed to make it water tight. This posed a risk of surfaces not being cleaned adequately increased risk of infection.
● In two of the cleaning rooms, the plaster walls were damaged and therefore compromised as there was bare plaster which could not be effectively cleaned.
● In one of the bathrooms on the ground floor bathroom there was a support rail to assist getting on and off the toilet. The stainless-steel arm was rusty and could not be cleaned effectively.
● There was a strong smell of urine in the main corridor on the ground floor, it appeared to be from the flooring.
● The rest of the home was found to be generally clean and tidy. Housekeeping staff were seen to be present and cleaning. Aprons and gloves were being used and changed frequently.
● One nurse could not find a single use lancet for a person who had diabetes. Lancets are used to prick the skin to take a small sample of blood. The nurse used their own lancet and sterilised it. This posed a risk of cross contamination. After our visit the provider told us that the nurse had been dismissed.

Assessing risk, safety monitoring and management
● Risk assessments lacked detail and conflicted with other information in the care plan. For example, on one person's risk assessment for pain it stated that the person could say when they were in pain. This conflicts with their care plan on cognition indicating that the person had limited communication with a brain impairment and memory difficulties.
● We requested the audit of the call bell which could have shown us how quickly staff responded to people's requests for assistance. The provider explained the laptop was broken which held the information and they

had removed it. This meant that call bell frequency and response could not be monitored and audited resulting in people being at risk of waiting unacceptable times for assistance.
● One staff member told us that a resident did not use the foot plates on the wheelchair because it caused them pain. This had been discussed with the family and they were keen that the footplates were not used. When we looked in the person's file, there was nothing in the care planning regarding the foot plates and no risk assessments.
● Risk assessments were poor and often lacked detail on how risks could be mitigated.
The provider failed to ensure they provided safe care and treatment to people. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● At our last inspection in May 2019 we noted that gates were being used on people's bedroom doorways to prevent other people entering their room. Risk assessments had been developed but were not robust enough and did not include the risk of a person climbing over the gate. We looked at the best interest decision for one person regarding installing the gate. This did not record how the decision was made and who was involved. There was also no date when the meeting took place. People had not been consulted on all of the gates being installed. The provider had told us that they had been requested.

The provider failed to ensure that consent was given to install gates onto peoples doors. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● We observed that one person's sensor mat was pushed underneath the bed. This would make the mat ineffective if the person experienced a fall. We informed the provider of this on three of our visits, the sensor mat remained tucked under the bed when we inspected on 30 July 2019. One person's crash mat was also not placed correctly. This posed a risk of a serious injury should the person fall out of bed. We were told by staff that this had been tucked away to give personal care, but staff had forgotten to replace it each time.
●Our third visit to the home was during the heatwave, temperatures were more than 35 degrees. This had been predicted and weather warnings issued. However, most people had no fans placed in their rooms. People who were at risk of dehydration were not having their fluid intake monitored. We found that one person who was on a fluid chart had a very low intake and dehydrated. This had been recorded but no action had been taken to ensure they took on more fluids during the hot weather.

The provider failed to ensure that people had enough to drink. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were cared for by staff who knew how to protect them from abuse. The provider had a safeguarding policy which staff were aware of.
● Staff told us that they had received safeguarding training and knew who to report through to. However, people thought that safeguarding should be reported through the manager therefore alerts were not being made if the manager was not on duty. None of the other staff knew how to raise the alert or investigate in their absence. .
● Some people living with dementia could experience periods of heightened anxiety and they displayed some challenging behaviour such as throwing heavy items. Staff had not been trained in behaviours that challenged and were therefore ill equipped to deal with situations which arose and unable to keep people safe. This was a risk of injury to other people, staff and visitors.

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 required improvement. There was a breach in Regulation 17 At this inspection this key question has now deteriorated to inadequate. The provider has failed to make improvements since the last inspection and continues to put people at risk.

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

- The home had been without a manager since April 2019. There was a manager in post but there had been no application to register. The assistant manager and clinical lead were also new in post. This meant that there was no effective leadership and management in the home to ensure there was sufficient oversight of staff and the care of people using the service.
- Systems and processes to monitor the safety and quality of the service continued to be ineffective. The provider had failed to act following our last inspection and had also not identified the additional concerns we identified during this inspection. We noted that the provider had been made aware of shortfalls by a local authority contracts visit prior to our inspection. The CCG were significantly concerned enough to allocate a professional to assist with making improvements to medication systems and processes. The demonstrated the provider's internal audits and checks continued to be insufficient.

The provider had failed to manage, monitor and mitigate risk. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People and their relatives were not consulted about their care or care planning. One person told us "We don't know about care plans.'' A relative said "I don't know about a care plan, before [name] came here the manager discussed his needs with us at a home visit.''
- Insufficient staffing numbers had hindered the provider's ability to provide good quality, safe care to people. The lack of consistent leadership has exacerbated the problem and reduced the provider's ability to develop a culture which was person-centred, open, inclusive and empowering.
- We saw isolated examples of care delivered by staff which was person centred. We also observed people sat in a lounge with no staff engagement or interaction for more than 10 minutes. One person was calling out but there were no staff present until we alerted them.
- Staff were not supervised effectively. There was no supervision taking place and no annual appraisal of performance. This meant that staff were given no support or direction in their role.

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 manager did not fully understand their duty to send in statutory notifications to the Care Quality Commission. Notifications are events that the registered person has a statutory requirement to inform us of.

● When we arrived at the home there was an ambulance outside. The person had two falls the previous day and had become unresponsive that morning. The provider had failed to notify us.

This is a breach of Regulation 18 of the Care Quality Commission (Registration Regulations 2009 (Part 4)

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● There was no formal or informal way of asking for feedback from people or their relatives. People were not asked what activities they would like to be involved in. People told us that they often weren't engaged in any activity because they did not enjoy what was provided.

● Staff had developed positive relationships with a range of health and social care professionals prior to and after the inspection visit. However, the management team failed to act on observations made by professionals who were supporting the service. This meant that improvements were not made in a timely manner and risks were not mitigated.

● Feedback we received from health and social care professionals prior to and after the inspection expressed similar concerns towards staffing levels and people's safety.

Continuous learning and improving care

● There was no evidence to show that there was a full analysis of incidents to consider lessons learned. Accidents and incident reports were not completed with a review by the manager and they were not used to inform improvements.

● There was no oversight by senior management to analyse and review systems and processes and no internal audit systems to ensure that standards were being met.

● The Management team did not engage with professionals supporting the home. After our third visit we were told that a peripatetic manager was being bought in along with other specialist staff employed by the company. We found significant concerns during our first inspection but there had been little progress made at each subsequent visit to the home. This meant that people remained at risk of avoidable harm.

● We saw that there was a complaints procedure and that complaints had been dealt with in a timely manner.

●The systems in place to assess, monitor and mitigate risks were not fully or consistently effective.

The provider has failed to learn from the previous inspection and make required improvements. The systems, processes and leadership had failed to assess, monitor and mitigate risks. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014

Working in partnership with others

● Staff had a commitment to want to work with external professionals to support people in meeting their individual needs and achieve good outcomes. However, the management team did not fully support the relationship with professionals and critical advice was not followed to improve care. They were not working in partnership as they had not taken on board the support given prior to and during the inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Best interest meetings were ineffective without relevant people involved. People were not consulted or asked for consent to care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's prescribed medicines were not managed effectively or safely. Policies for the management of medication were not adequate. Infection control was not sufficiently monitored and managed. Risk assessments were not in place or sufficient to monitor and mitigate risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's needs in relation to their nutrition and hydration had not been sufficiently assessed and timely support provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to assess, monitor and

mitigate risks were not fully or consistently effective.

Records relating to the care and treatment of people were not sufficiently accurate, detailed or kept up to date.