Care Quality Commission

Tamaris Healthcare (England) Limited

Regents View Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Regents View Care Home is a residential care home providing personal and nursing care for up to 50 people. At the time of our inspection there were 48 people using the service.

People's experience of using this service and what we found
There were not enough staff on duty to meet people's needs. The provider had not ensured risks to people had been assessed, monitored and managed. Recruitment processes had not been safely managed.

The provider's fire risk assessment was over 12 months old and although action was taken to address this after the inspection, the provide'rs own quality assurance systems had not identified this.

The home required refurbishment. Many areas of paintwork, flooring and furniture were worn. Curtains and blinds were missing from windows. The manager sent us a refurbishment plan after the inspection detailing the refurbishment to be carried out and timescale for completion.

Some quality monitoring systems were ineffective as they did not identify the areas of concern we found during this inspection.

Most people and relatives said they felt safe at the service and staff were kind and caring. However, some relatives did raise concern about some staff ignoring people or being rude.

People received support with their medicines and there were measures in place to prevent the spread of infections.

Accidents and incidents were well managed, with procedures in place to learn from these.

The provider had an open, transparent culture. People and staff all had opportunities to provide feedback about the service which was used to drive continuous improvement. Staff enjoyed their jobs and were all keen to deliver high-quality care. The manager and staff worked alongside other professionals to help ensure people received effective care and support.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection
The last rating for this service was good (published 11 July 2023).

Why we inspected
The inspection was prompted in part due to concerns received about the overall management of the service, limited activities, and the safety of care of people who use the service. A decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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 good to requires improvement. This is based on the findings at this inspection. Please see the full report for further details.

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

Enforcement
We have identified breaches in relation to safe care and treatment and the provider's oversight and management of the service.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Care Quality Commission

Regents View 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.

Inspection team
The inspection was carried out by 1 inspector, a regulatory co-ordinator and 2 Experts 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.

Service and service type
Regents View 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. Regents View is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a manager in post. However, they were not registered. They confirmed they had submitted their application for registration to CQC.

Notice of inspection
The 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 Healthwatch, the fire service and the local authority. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

The provider completed a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 18 people and 17 relatives about their experience of the care provided. We spoke with 14 members of staff including the manager, 2 regional managers, a care support manager, 7 care staff, the chef, a kitchen assistant, and the activity co-ordinator. We spoke to 2 visiting professionals.

We reviewed a range of records. This included 4 people's care records and 5 people's medicine records. We looked at 5 staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment
- An effective recruitment system was not fully in place. There was limited previous employment information in some staff recruitment files and gaps in employment had not been explored by the provider. The provider had not always obtained references from the staff members last employer.
- There were insufficient staff to meet people's needs. For example, in one of the dining rooms at lunchtime there were 4 people who needed help to eat but there were only 3 staff available. A person was sat with their food in front of them unable to eat it. This food had been there some time.
- We received mixed comments from relatives when we asked if there were enough staff on duty to meet people's needs. A relative said, "No there most definitely are not enough staff around. There are just 2 carers for at least 10 residents with some form of dementia. Staff can't feed 3 residents at the same time." Another relative said, "There are times when I think they could do with another set of hands, but when I need someone, I can always find someone." All care staff told us there were not enough staff to meet people's needs. We spoke with the regional manager who told us they would review staffing levels.
- People had limited access to activities as there was only 1 activities co-ordinator in post. We pointed this out to the regional manager who agreed with our findings and said they would look at this.
- Some relatives told us some staff were sometimes rude and people were sometimes ignored. We pointed this out the regional manager who said they would address this.

The failure to ensure enough staff were on duty to meet people's needs and failure to ensure recruitment processes were safe was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The providers recent audit in October 2023 had identified shortfalls with recruitment. The responsibility of recruitment was to be returned to the managers at location level to ensure recruitment procedures were robust.
- People were supported by staff who knew them, and their support needs well. Agency staff were being used to provide support to people, but they generally used the same agency staff to ensure consistency.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
- Risks to people's safety were not always assessed, monitored, and managed. We found toiletries were stored within people's bedrooms/bathrooms. Some of these people had dementia but there was no formal risk assessment or assessment to say this was safe. Some pull cords for lighting and the call bells were long and there was no risk assessment to assess if they are a strangulation risks to people.
- The fire risk assessment was over 12 months old. The manager took action during the inspection to

arrange for this to be completed and has since confirmed this has now been addressed.

The failure to ensure risks to people were assessed was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were systems in place to learn when things went wrong. Staff recorded all accidents and incidents. Analysis of incidents took place, and the manager was involved in reviewing these and implementing learning from this.
● The provider managed risks relating to the premises with regular safety checks, audits, and assessments.

Using medicines safely
● Medicines were safely managed. Medicines were stored appropriately. However, 2 medicine stock counts were incorrect. The count on the medicine administration record was not the same as the number of medicines we counted in the bottle. We provided feedback to the manager who said they would investigate this.
● Staff had received training in medicines management and their competency was assessed.

Systems and processes to safeguard people from the risk of abuse
● Systems and policies were in place to protect people from avoidable harm.
● People were protected from the risk of abuse. Managers and staff were aware of their responsibility to raise safeguarding concerns and liaise with the local authority and CQC.
● People told us they felt safe. A relative told us, "Yes [person], who has dementia, is quite safe because there are always carers around to observe [their] behaviour, as [they] can get quite anxious and abusive to other residents, although some of the new staff recently placed on the unit need time and support to understand [their] complex needs."
● During interviews with 2 of the relatives we did receive concerns about safety. This was brought to the attention of the manager, and we raised 2 safeguarding alerts to the local authority. These have been addressed outside of the inspection process.

Preventing and controlling infection
● The provider was keeping people safe from the risk of infection. We received feedback from some relatives that they could often smell odours in the service, but we did not find this during our inspection.
● People were able to receive visitors and leave the service line with current guidance
● The décor of the home did not promote effective infection control. Some areas of paintwork, flooring and furniture were worn. The manager sent us a refurbishment plan after the inspection detailing the refurbishment to be carried out and timescale for completion.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)
● We found staff were working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Requires Improvement

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

● Some quality monitoring systems were ineffective as they did not identify the areas of concern we found during this inspection. This included an out of date fire risk assessment, too few staff, lack of activities, unsafe recruitment procedures, worn furniture and décor.

● The provider had not ensured risks to people had been assessed, monitored, and managed.

The failure to ensure enough staff were on duty to meet people's needs and failure to ensure recruitment processes were safe was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The décor of the home did not promote effective infection control. Some areas of paintwork, flooring and furniture were worn. We also observed many of the gutters around the home were leaking. The manager sent us a refurbishment plan after the inspection detailing the refurbishment to be carried out and timescale for completion.

● The manager had submitted their application to CQC for assessment to become the registered manager.

● Staff received daily handovers to identify any key issues. Staff were knowledgeable about the people they supported.

● Action was taken when things went wrong to help make improvements.

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

● There was a positive culture which was person-centred, open and inclusive. Staff felt well supported and felt their opinions were valued. A staff member told us, "[Name of manager] is so supportive."

● Staff spoke positively about their work with the people they support. One staff member said, "I really enjoy my job as it is so rewarding."

● Staff felt able to raise concerns with managers without fear of what might happen as a result.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People and their relatives were asked for feedback on the service.

● Staff worked effectively with other healthcare professionals. During the inspection we spoke with 2 visiting

professionals. One professional told us, "They [staff] are very accommodating here." Another professional said, "The care is fantastic." Staff referred people to specialist services such as the falls team or behaviour team in a timely manner

● Meetings with people, their relatives and staff were held where any issues or suggestions could be raised.

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 understood their legal responsibility to be open and honest when something goes wrong. They submitted notifications to CQC for significant events that had occurred at the service, such as accidents and incidents.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's safety were not always assessed, monitored, and managed. The fire risk assessment was over 12 months old. Regulation 12 (1)(2)(a)(b)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance An effective system was not fully in place to monitor the quality and safety of the service and ensure there were enough staff on duty to meet people's needs. Recruitment processes were not followed to ensure the safety of people. Quality assurance systems were not always effective. Regulation 17 (1)(2)(a)(b)(d)