R G Care Ltd

The Paddocks

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

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
The Paddocks is a care home registered to accommodate and support up to 8 people with learning disabilities, autistic people and people with mental health needs. At the time of the inspection, 7 people were living at the home. People living in the home had their own bedrooms and there were shared communal spaces, including lounges, a kitchen and a garden area, all on one floor.

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

The provider had made improvements following our previous inspection, to make the home safer. Improvements were needed to reporting processes to ensure that accidents and incidents were investigated appropriately. We looked at staff meeting minutes, there was no discussion about people's incidents and accidents or how to prevent any future incidents.

Following the inspection, the provider sent us evidence to indicate they had made changes to improve accident and incidents.

Right 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 home supported this practice. The model of care at The Paddocks maximised people's choice, control and independence.

Staff were committed to supporting people in line with their preferences and supported people to receive their medicines safely and as prescribed. People were supported to access healthcare services to promote their wellbeing and help them to live healthy lives.

Staff managed risks to minimise restrictions, focusing on what people could do for themselves. The home had effective infection, prevention and control measures to keep people safe, including good arrangements for keeping the premises clean and hygienic.

Right Care:
Staff delivered care in line with information in people's care plans and recognised models of care for people with a learning disability or autistic people. This ensured people were receiving care tailored to them which promoted a good quality of life.

Staff had training on how to recognise and report abuse and they knew how to apply it. Staff recruitment, induction and training processes promoted safety, including those for agency staff. People were supported by staff who had received a wide range of relevant and good quality training to meet their needs.

Right Culture:
There was a positive culture at the home and people benefited from being supported by happy staff and this was reflected in the atmosphere at the home. Staff told us they enjoyed their job and making a positive difference to someone's life. Systems were in place to apologise to people, and those important to them, when things went wrong.

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 29 June 2022) and there were breaches of Regulation 13 (safeguarding service users from abuse and improper treatment) and Regulation 17 (good governance). The provider completed an action plan after the last inspection to show what they would do to improve. At this inspection we found improvements had been made and the provider was no longer in breach of these regulations.

Why we inspected
This was a planned inspection based on the previous rating and when the service was last inspected.

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 and Well-led which contain those requirements.

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 remained the same. This is based on the findings at this inspection.

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

Enforcement and Recommendations
We have identified breach in relation to safe care and treatment at this inspection. We have also made a recommendation to follow best practice guidance around quality assurance.

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

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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

The Paddocks

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
This inspection was carried out by 1 inspector and 1 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.

Service and service type
The Paddocks is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement dependent on their registration with us. The Paddocks 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
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 not a registered manager in post. A new manager had been appointed and was due to start in August 2023. We were supported by the area manager and deputy manager, who was a representative of the provider and was managing the service.

Notice of inspection
We gave a short period of notice of the inspection because some of the people using it could not consent to a home visit from an inspector. This meant that we had to arrange for a 'best interests' decision about this.

Inspection activity started on 26 July 2023 and ended on 31 July 2023. We visited the location on 26 July 2023.

What we did before the inspection
The provider was not asked to complete 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 sought feedback from the local authority who work with the service. We reviewed the information we already held about the service. This included their registration report and notifications. A notification is information about important events, which the provider is required to tell us about by law. We used all of this information to plan our inspection.

During the inspection
We reviewed a range of records. This included 2 people's care records. We looked at 3 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including audits, incidents and accidents were reviewed. We reviewed 4 medicine administration records. We spoke with 6 members of staff including the area manager, deputy manager, 2 support workers and 2 agency staff. We were able to get limited views from people only due to their needs.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We continued to seek clarification from the provider to validate evidence found.

We looked at care records, staff training records and policies and procedures. After the inspection, we spoke with 6 relatives by telephone about their experience of the care provided.

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 requires improvement. The rating for this key question has remained the same. 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.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

At our last inspection the provider systems failed to report incidents where people were at risk of abuse or coming to harm. This was a breach of regulation 13(2) (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● At our last inspection, procedures for the recording of incidents and accidents were not always followed. We noted from staff meeting minutes the provider had previously discussed recording incidents and behaviours on the electronic system.
● The provider told us they would review the incidents and discuss these with all staff involved. They would ensure there was a more consistent approach and response to the reporting of incidents and safeguarding concerns.
● At this inspection we looked at 1 incident which took place in April 2023, and 10 incidents in May 2023. These were recorded in the incident and accident system which showed what action had been taken by staff and was signed off by the provider. However, we did not see any evidence of this being shared with staff, or, what actions had been taken to mitigate future risks.
● An accident and incident policy was in place, but the provider was not following their policy. These failures evidenced a lack of learning from events or action taken to improve safety, placing people at risk of harm. There were no examples of reflective practice or that this information was being discussed with staff.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safe care and treatment was being provided in a safe way for service users. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had been trained on safeguarding and were aware of what action to take if they witnessed signs of abuse. One staff member told us, "I will contact my manager, and tell them what happened. If nothing happens, I will contact the local authority."
● Relatives told us their family member felt safe and well looked after at the home. One relative said, " I trust The Paddocks and the care staff implicitly, they know him inside out. They care deeply about [person] and when sees staff [person] squeals with delight."

● Where concerns had been raised the provider and deputy manager had worked collaboratively with health and social care professionals to keep people safe.
● The provider had a whistleblowing policy which guided staff on how they could raise concerns about any unsafe practice.

Assessing risk, safety monitoring and management
● Sufficient risk assessments were in place to ensure people received safe care.
● People's care plans contained risk assessments, which included risks associated with behaviours that may challenge others, medicine management, epilepsy, and people with a learning disability. For example, one person was at risk of seizures. There was guidance for staff on what to do in the event of seizure and who to contact.
● People had a personal emergency evacuation plan (PEEP) advising staff on the help they needed to evacuate the premises in the event of a fire.
● Checks and maintenance were carried out on the premises and equipment with records maintained to help ensure they were safe. For example, electrical safety systems and equipment were serviced by qualified persons and tested to ensure they worked properly by staff at the service. Other safety checks included gas, legionnaire and lift equipment.

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 the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.
● People were supported in line with the principles of the MCA. Where people were thought to not have capacity to make certain decisions, capacity assessments had been carried out.
● Where applicable, the provider had ensured authorisations for DoLS were in place for people whose liberty was being deprived. DoLs applications for each person were more up to date along with restrictions and conditions for people's personal safety. The provider kept a log of DoLS applications that had been made, were in progress or had been approved.
● Staff understood the principles of the MCA and had received training. They told us they asked for people's consent at all times before providing them with support.

Staffing and recruitment
● There were sufficient staff available with the right skills and experience to meet the individual needs of people who used the service.
● The provider's recruitment, assessment and induction training processes promoted safety and the culture and values of the service. The provider carried out thorough checks on new staff before they started work. This included carrying out a Disclosure and Barring Service (DBS) check. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● Relatives told us there were enough staff working at the service. One relative said, "There are enough staff on duty." One member of staff told us, "We do have enough staff working."
● A staffing rota showed the shift arrangements for the week. Agency staff were used but they were regular and were familiar with the service. During our visits to the home we saw there were enough staff deployed to meet people's needs and to respond to emergencies.

Using medicines safely
● Medicines were being managed safely. Locked cabinets were in place and all medicines and records were safely stored. Temperature checks were carried out to ensure medicines were stored at the correct temperature. Any medicines that were required to be kept in the fridge were done so safely.
● People received their medicines when they needed them. They had received training and understood the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured that people's medicines were reviewed by prescribers in line with these principles.
● The home used electronic medicines administration records (MARs). We reviewed MARs and saw evidence that people received their medicines as prescribed, and 'when required' (known as PRN medicines) were given as needed.
● Staff had received up to date medicines training. They were able to explain the process of safely administering medicines, the importance of time-critical medicines and 'when required' medicines

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 supporting people living at the service to minimise the spread of infection.
● 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 responding effectively to risks and signs of infection.
● 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
● Visitors were allowed to visit their loved ones whenever they wanted. There were no restrictions on visitors.

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 requires improvement. The rating for this key question has remained the same. 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

At our last inspection the providers systems to assess, monitor and mitigate risks to the health, safety and welfare of people using the service were not always robust. This was a breach of regulation 17(1) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

● At our last inspection, we identified improvement was needed on the reporting of incidents. The provider confirmed that all incidents should have had an associated incident report. This meant the provider was not always aware of what incidents had occurred to review and learn lessons.
● At this inspection, there was a lack of systems in place to analyse events, accidents and incidents to identify what went wrong so action could be taken to help rectify things to prevent similar issues from reoccurring. There was therefore little assurance that any such events or incidents and accidents that had happened previously, would not happen again.
● The provider completed a mock inspection which was led by their site manager. The report was completed in June 2023 and had identified the issue we found with staff meetings, in that incidents and accidents were not being discussed. This issue had not been addressed despite being well known by the provider.
● We looked at 3 staff meeting minutes, staff were informed through staff meetings of concerns found from their safeguarding discussions, improving practices, people they supported and medicines. There was no discussion about people's incidents and accidents or how to prevent any future incidents.
● During our inspection, the provider confirmed they accepted that their quality assurance systems had not operated as well as they should.

We recommend seeks advice from a reputable source about following best practice guidance on quality assurance and review of all existing systems.

● Following our inspection, the management team sent us a recent staff meeting minutes on how they had addressed the above concerns.
● We identified concerns in relation to the oversight, operation and management of the service. The

registered manager had recently left their post, and there was a new manager being recruited at the time of the inspection.
● There were quality assurance processes in place. Various audits were carried out by the provider including audits of medicine records, daily notes and infection control practices, while care plans were subject to regular review.
● The provider was clear about their role and responsibilities. They understood the regulatory requirements of their role and had notified the CQC when required of events and incidents that had occurred at the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff told us they enjoyed working at The Paddocks and would recommend the home to friends and family. One staff member told us, "We give person centred care and [peoples] individual needs are met. For example, food, activities, community access and contact with families. We always involve service users in all decisions about themselves."
● The provider completed spot checks to ensure staff were delivering good quality, safe care.
● People and relatives all knew who the provider was and told us they felt confident in raising any concerns with them.

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 was aware of when the CQC should be made aware of events and the responsibilities of being a manager. They have reported events and accidents and incidents to CQC when these had occurred and as required by law. Certificates of registration and the ratings were on display in the communal areas, as well as their employer's liability insurance certificate.
● The provider and the deputy manager understood their responsibilities under the duty of candour. The provider and the deputy manager had been open and transparent with people when incidents occurred where the duty of candour applied.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff felt involved and they had good working relationships with the management team.
● Staff told us they received the necessary support from the management team when needed. Comments included, "The director is ok. I communicate with them if there is an emergency" and "It's ok. I don't have any complaints. I can get hold of [name of the manager], if they don't answer straight away, they will get back to you."

Working in partnership with others
● The provider and staff worked in partnership with other health professionals to achieve positive outcomes for people. People's care records showed involvement and guidance from other agencies such as GPs, district nurses, speech and language therapists and pharmacy.

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 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. Regulation 12(1)