Camino Healthcare Limited

Vestige Healthcare (Dudley Port)

Inspection report

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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
Vestige Healthcare (Dudley Port) is a short stay service providing personal and nursing care, treatment for disease, disorder or injury and/or diagnostic and screening procedures to 12 people with Learning Disabilities and Mental Health needs. The service can support up to 16 people.

Vestige Healthcare (Dudley Port) accommodates 10 people in one purpose-built building and has a further two houses adjacent to the main building that accommodates a further two people.

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

People were not protected from the risk of abuse. Records held relating to both physical and chemical restraint did not provide assurances that restraint was being completed safely and only when absolutely necessary. Chemical restraint is the use of medication to control or subdue behaviour. Due consideration had not been given to principles under the Mental Health Act Code of Practice in relation to restrictive practices for one person.

Risks to people's health, safety and wellbeing were not consistently assessed. Key pieces of information relating to people's care and treatment needs were not recorded. There had been no consideration for what support people may need if there were a deterioration in their mental health and their needs could no longer be met at the service.

Medicines were not always managed in a safe way. Sufficient guidance for the use of 'as and when required' medicines was not always available and there was no oversight of the use of these medicines. There was a risk of medication errors due to a poor understanding of legal responsibilities and documentation not being accurate and up to date.

Systems in place to monitor quality of care had failed to identify the areas for concern we found at this inspection.

The provider had risk assessed the use of personal protective equipment in relation to COVID-19. Based on the risk assessment, the decision had been made not to follow the national guidance as this had a negative effect on people's mental health.

Although there was a high usage of agency staff, people reported that they knew their staff team and had sufficient numbers of staff available to support them.

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 Requires Improvement (Published 12 March 2020)

Why we inspected
We received concerns in relation to the management of risks; particularly around behaviours that can challenge. As a result, we undertook a focused inspection to review the key questions of Safe and Well Led only.

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 full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Vestige Healthcare (Dudley Port) 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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to keeping people safe, and the managerial oversight at this inspection. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

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.

Vestige Healthcare (Dudley Port)

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
The first day of inspection was completed by one inspector and one inspection manager. The second day of inspection was completed by an inspector, an inspection manager and a Mental Health Act Reviewer. A third day of inspection was carried out by two inspectors.

Service and service type
Vestige Healthcare (Dudley Port) is a 'care home'. People in care homes receive accommodation and nursing or personal care, treatment for disease, disorder or injury and/or diagnostic and screening procedures as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
We gave a short notice period of the inspection because of the risks associated with Covid-19. This meant that we could discuss how to ensure everyone remained safe during the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they

plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection-
We spoke with three people who use the service. We spoke with seven members of staff, as well as the manager and the Nominated Individual. We reviewed care records for eight people as well as viewing medicine records, incident forms, staff rota's and records relating to quality assurance.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We reviewed documents relating to quality assurance and incidents. We spoke with three relatives via telephone as well as four health professionals.

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.

Systems and processes to safeguard people from the risk of abuse

● The provider failed to safeguard people from the risk of abuse. On the first two days of inspection, one person was being segregated and was receiving 'as and when required' medication on a frequent basis to manage their behaviours. Due consideration had not been given to principles under the Mental Health Act Code of Practice in relation to restrictive practices for this person. The person told us they had recently self-harmed in order to be able to leave the segregation. The provider confirmed this incident took place. Although the provider had acknowledged they could not meet the person's needs, no immediate plans had been implemented to ensure the person was moved to a setting appropriate for their needs. We took immediate action alongside the provider and the funding authorities to ensure this person was made safe.

●Three people had been subject to physical restraints and a further one had experienced chemical restraint. Records held in relation to these incidents did not provide the necessary information so the provider could ensure these actions were only taken where absolutely necessary. The records did not provide sufficient information on the type of restraint used, by whom and for how long. This meant the provider was unable to determine whether these restrictions on people had been applied safely.

● Although staff had been trained in the safe use of restraint, records for one person indicated they had been restrained in a way that was not safe. An incident of restraint was also witnessed by members of the inspection team that indicated restraint was not applied in a safe way. We took action to safeguard people by notifying the local authority safeguarding team.

The failure to ensure that acts to restrain people were proportionate and only carried out when necessary is a breach of Regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management, Using medicines safely

● Although some care records provided detailed information about people and any associated risks, this was not applied consistently for all people. Some risk assessments were only partially complete or left blank. The lack of information available placed people at risk of harm. Staff however, informed us they knew people's needs.

●We saw risk assessments that did not reference use of restraint, although restraint was being used on the person. This meant appropriate information about what kind of restraint was safe to use for the person was not available for staff. This placed people at risk or harm through inappropriate or unsafe restraint.

● On the third day of inspection, in response to the concerns raised, the provider told us they had started to review, and update people's care plans and risk assessments. We reviewed one updated plan for a person relating to how to restrain them safely. The plan had not considered medical needs the person had and how

they could impact on them during restraint. This meant information about risks to people was still not easily accessible for staff. We discussed this with the provider who told us they would update the plan.
●Following the inspection, the provider provided copies of care plans and risk assessments relating to the use of restraint for one person who's records were not available on the day of inspection
● Where people required medicine on an 'as and when required' basis, there was no detailed guidance provided to staff advising when this should be administered. For one person, we found they were receiving their 'as and when required' medicine on a daily basis, without any record or explanation for the high usage. This daily use of 'as and when needed' medicines had not been reviewed by the provider to ensure this was safe for the person. Following the inspection, the provider sent evidence of updated protocols giving further detail to staff about the safe administration of 'as and when required medicines.
● One person was receiving medicines via intramuscular injection (IM). IM medicines are medicines that are injected into the muscle so that they are absorbed more quickly. There was no guidance or care plan for staff on when this type of medicine should be administered. We were unable to see where this had been administered and what de-escalation techniques had been trialled prior to the use of these medicines. Although the provider informed us they felt this was appropriate use of medicine, they were unable to provide evidence to show the reasons for administration. On the third day of inspection, a local pharmacy was onsite at the provider's request to audit medicines and the use of 'as and when needed' medicines.

The failure to ensure the safe management of medicines and to ensure risks to people's safety were assessed is a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The provider was using a high number of agency staff to ensure sufficient staffing levels. Staff gave mixed feedback about this. One staff member told us, "Yes there is enough staff. I am not a fan of all the agency (staff) although they are good. I do think there needs to be a more permanent staff base".
● We saw from staff rotas on some days, there were only one or two members of permanent staff on site; with the main staff team comprising of agency staff. We spoke with the provider about this who advised that they intended to take these agency staff on permanently after a 12-week period. Should the agency staff take up this offer of permanent employment, the service would have their own staff team; reducing the need for agency use.
● People told us they were supported by a consistent team of staff and they had good relationships with their staff team. One person said, "I get on well with staff. They are always around, night and day". We saw there were sufficient numbers of staff to support people.

Learning lessons when things go wrong
● The provider's systems had failed to identify areas of concern we found at the inspection. This meant that it would not be possible for the provider to effectively learn lessons, as their current systems were not identifying poor practice. The provider expressed to us their willingness to learn lessons where things had gone wrong. Where we identified areas of risk during our inspection, the provider gave assurances that these would be addressed, and new systems implemented.

Preventing and controlling infection
● The provider was not following national COVID-19 guidance in relation to wearing of personal protective equipment (PPE). The provider informed us they had made this decision as the wearing of PPE had caused people distress. The provider sent us a copy of their risk assessment in relation to this.
● There was a domestic team in place responsible for the cleanliness of the home. We found the home to be

clean, tidy and free from odour.

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 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

●The provider's governance systems failed to identify that they were not having due regard to the Mental Health Act Code of Practice. One person told us their stay at the home had a negative impact on their well-being. The person said, "I have been left here to suffocate like a prisoner."

● The provider's systems to monitor the quality of care failed to be effective in identifying the areas of concern we found at this inspection.

● The provider failed to have oversight of the restraints being placed upon people to determine if they were completed safely. Reviews of individual restraints had not taken place and poor recording of incidents had not been identified. The provider's restrictive practice audit did not look into the use of restraint. Following the inspection, the provider submitted a copy of a restraint audit that had identified some areas for improvement around restraint records. However, these had not yet improved the quality of restraint records to ensure the provider could appropriately oversee restraint use.

● The provider's systems failed to identify the high usage of 'as and when required' medicines and had not reviewed staff administration of this to ensure safe usage. The provider's quality assurance systems had not identified there was no rapid tranquilisation guidance for staff to follow in relation to IM medicines. This meant the provider would be unable to ensure these medicines were given in a consistent manner and in a way that met the person's needs.

● The provider's systems had failed to identify that there was a risk of medication errors for one person. The provider had not ensured that they were clear who could prescribe medicines under the Mental Health Act and documentation had not been kept up to date and accurate.

● The provider's systems failed to identify care records were not always complete or accurate. We found care plans that were at times blank or lacked robust detail about how people's needs should be met. Although care plan audits were in place, the lack of detail in the care plans had not been identified. The risk around lack of records was heightened by the high usage of agency staff who would require this guidance to meet people's needs. Following the inspection, the provider sent an updated care plan to show how these had been updated to provide additional details.

● People admitted into the service had complex needs and behaviours that challenged including harm to themselves and others. There had been no consideration for what support people may need if there were a deterioration in their mental health and their needs could no longer be met at the service. Following the third day site visit, admission documentation was updated to ensure people had a moving on option if the person's health needs increased and they were no longer safe in a community setting.

The failure to implement quality assurance systems to identify the areas for improvement found at this inspection is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider was not meeting the regulatory requirements of their role. The provider had a condition on their registration requiring there to be a registered manager in post. At the time of the inspection there was no registered manager in post.

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

● The provider had not consistently ensured an empowering service that achieved good outcomes for people. There had been a significant impact on one person's wellbeing following their stay at the home. Their stay at the home had not been person centred or empowering.

● The provider acknowledged one person's needs could not be met at the home and following the second day of the inspection was able to ensure the person moved to a more appropriate setting. For others, the lack of guidance for staff around the use of restraint; both physical and chemical meant the provider was unable to ensure that people consistently received safe, person centred support.

● The provider could demonstrate improvement in some people's health conditions following their stay at the home. For example, one person's behaviours that challenged had reduced and there was less restraint required.

● Staff reported to us the management team were available to them and felt they were approachable. However, some staff reported the management team at times gave them mixed messages around the type of service they could provide. One staff member said, "There have been teething problems and some of these were caused by management. The message hasn't been clear about what we are [the type of service provided]." Another staff member added, "They [management] are inconsistent with their advice. If say someone wants to go out, one [manager] might say no they can't, and another [manager] might say yes they can".

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

● We saw recent records of staff meetings that had taken place although staff we spoke with told us they had not attended these meetings. We were therefore unable to obtain their opinions on the quality of the meetings. One staff member told us, "They don't ask us for our feedback."

● Although we were unable to view any formal feedback from people, people told us they knew the management team and some people were asked for their feedback informally. One person told us, "They [managers] do come and check I'm ok." A relative added, "I have actually heard from the manager. They are really good. They are always there and will chat to me." Following the inspection, the provider sent examples of feedback they had received previously.

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

● For one person placed into segregation, the provider had not always been open and honest with them when something had gone wrong with their care and treatment. This had led to the person becoming increasingly distressed as they told us they did not understand why they continued to be segregated as part of their care.

●The provider had advised CQC and external agencies where incidents had occurred, and relatives informed us they were also kept informed of incidents where required.

Continuous learning and improving care; Working in partnership with others

● We received positive feedback from external agencies working with the provider. One professional told us, "We have seen some really positive outcomes for people we have placed there." Some professionals advised that communication with the provider had been difficult at times but that they had raised this directly with the provider who had responded appropriately.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed in a safe way. Risk assessments did not always provide sufficient guidance on how people should be supported safely.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from the risk of abuse. Records held relating to both physical and chemical restraint did not provide assurances that restraint was being completed safely and only when absolutely necessary.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems had not identified the areas of risk found at this inspection.

The enforcement action we took:

Warning Notice