Villcare Limited

Villcare Limited - Eastbury Road

Inspection report

51 Eastbury Road
Watford
Hertfordshire
WD19 4JN

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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
Villcare Ltd Eastbury Road is a care home providing personal care to two people. The home is a bungalow with a garden and access to the local town. Most people who were living at Villcare Ltd Eastbury Road had a physical and learning disabilities, including autistic people. The home can support up to four people.

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

Right Support
● People had not gone out since lock down ended to pursue their interests and do things they enjoyed. Plans and strategies had not been made to promote this part of people's well-being and to explore their interests.
● People received their medicines as prescribed. But staff did not have training on how to administer one person's medicine. Nor had this person been consulted with and involved in the plans of how this would happen.
● Meetings took place with people about their support and care. But these did not cover all aspects of their care, their goals and aspirations. The records of these meetings were not in formats people themselves could understand.

Right Care
● The physical environment of the home looked tired and in need of redecoration. Spaces in the home were not personalised, this included people's bedrooms. Most of the living rooms had information for staff to read and look at, like you may expect to see in a staff room. Plans had not been made to help people to utilise and enjoy their home and garden.
● Staff were polite with people and they checked they were okay. However, staff did not speak with people in a social way or help them follow their interests.
● There were gaps in staff's knowledge in terms of promoting people's safety from experiencing potential abuse and harm. Understanding the risks people faced and responding to a potential fire.
● The registered manager had ensured various building safety checks had been completed. There were enough staff to meet peoples care needs.

Right Culture
● The leadership of the home had not empowered people to have ownership of their home. The culture was

not fully person centred and failed to focus on the individual, their interests or advocate on their behalf when necessary.
● When new people came to stay at the home, people were not consulted with in a meaningful way, to see if they were happy about this. We also found shortfalls when a new person came to stay at the home in terms of assessing risks and making plans to support them and others to be safe.
● The provider and registered manager's audits to check the quality of care provided were not effective in relation to monitoring the standard of care people received, responding to incidents and changes in need and considering if people had full risk assessments and plans for staff to follow.
● The service lacked pro-active leadership. The provider and registered manager did not keep up with changes to regulatory expectations and development of best practice standards. They failed to assess people's experiences to see if improvements to practice and systems could be made.
● People were not being given opportunities small or large to promote their interests and make plans for the future. The ethos of the leadership of the home had not considered whether the service reflected these values nor were they making plans to do so.
● The registered manager told us they were committed to making improvements and to make changes.

Based on our review of safe and well led the service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

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 in 5 April 2018).

Why we inspected
We undertook this inspection to assess whether the service is applying the principles of Right support right care right culture. This inspection was prompted by a review of the information we held about this service.

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.

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

We have identified breaches in relation to supporting people to be safe, ensuring they have a person-centred care experience and how well led the home is.

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, 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

Villcare Limited - Eastbury Road

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
This inspection was completed by one inspector.

Service and service type
Villcare Ltd Eastbury Road 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. Villcare Ltd Eastbury Road 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 service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave an hours' notice as the home was small supporting two people and we wanted to check if a member of staff would be available to let us in.

Inspection activity started on 26 April 2022 and ended on 12 May 2022. We visited the home on 26 April 2022 and 6 May 2022.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We spoke with the local authority to gain their views of the home and we reviewed the records we hold. We used all this information to plan our inspection.

During the inspection
We spoke with one person's relative about their experience of the care provided. People who used the service who were unable to talk with us and used different ways of communicating such as body language and pictures. We spent lots of time seeing how staff supported people in their day to day lives at the home.

We spoke with four members of staff, the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We looked at a series of documents on each visit to the home. Staff recruitment files, fire safety checks, risk assessments, care plans, incident forms, meetings notes, and medicines records. We requested further documents such as audits, risk assessments, care plans, daily notes and emergency plans to be sent to us electronically.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
● When a new person came to stay at the home for a temporary period, a full assessment of risks they faced had not been made prior to them arriving. They were at risk of leaving the home alone, but there were no plans made about how to manage this. This person's needs were not being reviewed during their stay and when they indicated unhappiness, this was not addressed

● Other people had risk assessments in place, but some lacked key information. One person could get distressed when they were being supported to move with equipment. This was not explored with a plan made and instead staff had wrapped a towel over part of this equipment and secured it with sellotape.
● Some staff did not know what the key risks were which people faced. This included the risks of choking and pressure care.
● When a person had a particular type of seizure, no health professional was contacted to check if the registered manager or staff needed to do anything else other than record this. This person did not have a full risk assessment or a care plan which directed staff about this specific need.
● The fire evacuation plans in place for people, had not considered what the plans were when there are fewer staff on duty at night time and weekends. When we spoke with staff about what happened if the fire alarm went off, one member of staff said they would first reset it. If there was a fire both staff said they would re-enter the building to evacuate people. We spoke with the registered manager about our concerns with staff knowledge and the existing plans. They arranged for the fire service to visit and help rectify these fire safety issues.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● When a potential safeguarding event took place, when a person left the home in an unsafe way and the police were called, a safeguarding referral was not made about this. The ambulance crew said they would raise one, so the registered manager did not, however this is something they should have done.
● Some staff did not know what the potential signs of abuse could look like, which meant they could miss abuse if they were not able to recognise it. Staff all said they would report concerns to the registered manager. But some staff did not know who else and how they could report their concerns to outside of the home such as CQC or the local authority safeguarding team.
● When an incident or accident took place, there was no analysis of this to consider if lessons could be learnt.

Using medicines safely;
● One person required a medicine to be administered to them which staff did not routinely administer, but it

required a certain skill to do this safely. Staff had not had training and support on how to do this. This placed this person at potential risk of harm. Four weeks after the inspection was completed the registered manager found a certificate to say only one member of staff had training to complete this task. Also, the registered manager had not assured themselves all staff could perform this task safely.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people living at the home. This placed people at potential risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We spoke with a person's relative who was confident their loved one was safe in the home.
● Other safety checks were completed such as a building fire risk assessment and fire related equipment was also checked regularly.
● We completed a count of people's medicines and these tallied with the amount which should have been given.

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 in relation to daily living needs and applications to make authorisations had been made to deprive a person of their liberty.
● Best interest processes had been completed for some people regarding certain decisions and a mental health advocate had been involved. However, the records did not show who this was and what they had done.

Staffing and recruitment
● There were enough staff to meet people's care needs.
● Staff recruitment checks had been completed to ensure staff were safe to support people. This included verifying staff identities and completing Disclosure and Barring Service (DBS) checks.
● The registered manager also had a system of verifying these checks had been completed when they used agency staff.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was 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.

We have also signposted the provider to resources to develop their approach.

● The registered manager had opened the home to visiting relatives if they wanted to visit.

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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● There was not a person-centred culture at the home. People had not gone out socially since the end of lock down. There were no plans being made to make this happen for people despite it being noted one person did enjoy this, and another person had in the past.
● People had some key interests, but these were not being explored with them. Opportunities to develop these interests and make life more enjoyable were not being considered.
● Staff did not engage with people other than in relation to checking they were okay and supporting them with meals. They were not trying to make life interesting and promote people's interests.
● We identified from looking at people's daily notes, staff were assisting people to change their incontinence equipment, but there were often long gaps of six and five hours of doing this. The registered manager told us no one had any pressure damage to their skin. However, this was not personalised and thoughtful care.
● There was a lack of advocating for people. When a person repeatedly refused to see a health professional no attempts were made to find a solution for them. When a complaint, safeguarding, or review of care was needed to promote people's rights this was not happening. People were not being involved in the development of the home or discussions when changes happened.
● The environment looked tired with marks on the walls. Rooms were not personalised. Brown sellotape secured TV cables on walls in people's rooms. The carpet was old and was rucked up in one person's room. Another person's room had a leaking portable radiator. CD's were still in a carboard box beside a person's bed unused, even though they liked listening to music. The garden had not been made fully accessible or a part of people's home.
● There was multiple paperwork in the lounge and hallway for staff to look at, such as information on epilepsy, how to whistle blow, and the fire warden aluminous jacket hung on a hanger. On the front door the various government agency ratings were displayed. In people's room IPC advice for staff were obviously displayed. This made the environment look institutional and not like somebody's home.

There was not a person-centred culture at Villcare. Systems had not been established to assess and monitor this aspect of people's lives. This placed people at potential risk of harm in relation to their well-being and mental health. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Managers and staff did not fully understand every aspect of their role. Auditing was taking place, but the provider and registered manager were not assessing people's experience of living in the home. There was no focus on whether people received a person-centred experience at the home with action taken to improve this where necessary.
● There were also shortfalls in risk monitoring in relation to reviewing incidents and accidents, changes in need for some people, whether people coming to stay at the home did so safely and checking everything was covered regarding fire safety. The audits had not identified these issues.
● When an incident or accident took place, there was no analysis of this to consider if lessons could be learnt, if a person needed a review of their care, or if something could be done differently next time.
● The registered manager and provider had not kept up to date with changes in best practice and regulatory expectations. Focusing on people's quality of life, their experiences, and fulfilling their interests,
● We were not notified when certain events happened at the home, when we should have been informed by law. When the police were called for one person and when a safeguarding investigation was underway by the local authority, we were not informed of these.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Attempts to communicate with people in ways which might improve their participation in their daily routines and bigger choices were not being explored with people.
● People had meetings with the registered manager, but the notes of these were handwritten and not supportive of people's preferred methods of communication. Nor did these meetings try to consider new ideas and opportunities for people.
● Staff said they were kept up to date about people's needs.

There were key shortfalls with how the provider and registered manager assessed the quality of the care provided at Villcare. Robust systems had not been established which were used to effectively assess and monitor the standard of care at the home. This placed people at potential risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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; Working in partnership with others
● There was a complaints process in place. Staff and a person's relative felt confident in approaching the registered manager to raise an issue.
● The registered manager had worked with some people's health professionals in relation to some people's health needs. However, attempts to bring other specialists to consider people's experiences and their environment had not been considered.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care There was not a person-centred culture at Villcare Ltd Eastbury Road. Systems had not been established to assess and monitor this aspect of people's lives. This placed people at potential risk of harm in relation to their well-being and mental health.

The enforcement action we took:

A warning notice was served due to the failures identified at this inspection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	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 living at the home. This placed people at potential risk of harm.

The enforcement action we took:

A warning notice was served due to the failures identified at this inspection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were key shortfalls with how the provider and registered manager assessed the quality of the care provided at Villcare Ltd Eastbury Road. Robust systems had not been established which were used to effectively assess and monitor the standard of care at the home. This placed people at potential risk of harm.

The enforcement action we took:

A warning notice was served due to the failures identified at this inspection.