Tiddington Court Limited

Tiddington Court Limited

Inspection report

Knights Lane
Tiddington
Stratford Upon Avon
Warwickshire
CV37 7BP

Tel: 01789204200

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Tiddington Court is registered to provide personal care to older people. Care and support was provided to people at pre-arranged times in a specialist 'independent living' service. Tiddington Court consists of 30 apartments and 12 bungalows. People living at Tiddington Court own their own home and share on-site communal facilities such as a passenger lift, lounge, dining room and the use of an on-site restaurant.

This provider is based at Tiddington Court and provides emergency support to everyone living there. Planned day to day personal care can be provided by staff based at this site or from other agencies who provide personal care and support packages. Not everyone living at Tiddington Court receives a regulated activity of personal care. At the time of this inspection visit, Tiddington Court staff supported three people, so we only looked at the care and support for those three people receiving personal care from this provider.

People's experience of using this service
At the previous inspection, provider audits needed to be improved and become embedded. At this visit we found those improvements had not been made. We asked to look at audits for incident and accidents, analysis of falls, care plan audits, risk management, staff training, complaints, medicines and survey questionnaires to see how actions had been taken to drive improvements. Some of the analysis of information was either not completed or inaccurate, so we could not be confident actions were taken when improvements were identified. This meant the registered manager and the provider had limited assurances people received a safe, effective and well led service.

We looked at infection prevention and control measures under the Safe key question. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. Infection control systems implemented during a pandemic were in place, however these were not always followed and observed. People and staff told us on some occasions, face masks were not worn when providing personal care. During our visit, the management team were based in a small office and on occasions, up to four senior staff were seen, not socially distancing and not wearing a face mask in line with government guidelines. Some of these staff could meet those people who received a regulated activity.

People's plans of care were not detailed enough for staff to provide safe care. The registered manager was in the process of updating those plans with important information that staff needed to know. Staff's knowledge of how to support people was inconsistent.

Risks related to people's care were not recorded, accurate and reviewed. Some risks were scored, however there was no instructions for staff to follow to manage those identified risks. Where people were at risk of falling, records were not consistent with events and although falls analysis was completed, it failed to record all falls and incidents. In some examples, intervention by a GP or falls team was suggested. There was no evidence to show, this had been followed.

Staffing levels met people's needs. People told us staff supported them in an unrushed manner and were able to respond to requests for support without any undue delay.

People receiving personal care, spoke positively about their experiences living at Tiddington Court and the quality of their care demonstrated by the staff team.

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 28 November 2018)

Why we inspected
The inspection was prompted in part due to information received about concerns in relation to staff supporting people with personal care, a lack of training, staff not adhering to government guidelines with PPE and a culture of staff not feeling supported. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe, effective and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Tiddington Court 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 a breach in relation to safe care and treatment and good governance at this inspection.

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 for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Further information is in the detailed findings below.

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 effective?

Good

The service remained effective. Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well led. Details are in our well led findings below.

Tiddington Court Limited

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector.

Service and service type
This service provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

The service had a manager registered with the Care Quality Commission. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
Our inspection was announced. We gave the service 45 minutes notice of our visit because the service was inspected during the coronavirus pandemic and we wanted to be sure we were informed of the home's coronavirus risk assessment for visiting healthcare professionals before we entered the building.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection and recurrent themes of concerns. We sought feedback from the local authority and commissioners who may work with the service. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection visit
We spoke with three people who lived at Tiddington Court about their experiences of the care provided. We spoke with a registered manager, a duty manager and a care staff member. We also spoke with a service manager.

We reviewed three people's care records in detail. We looked at a sample of records relating to the management of the service including health and safety checks, accident and incident records, policies and procedures and a sample of records the registered manager said they checked, such as daily records and cleaning schedules.

After the inspection
We contacted four care staff but were only able to speak with two care staff via the telephone. We reviewed the additional documentation we had requested from the registered manager during the site visit. 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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant some aspects of the service were not always safe to provide assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
At our last inspection we found risk assessments were basic and were not following recognised risk assessment tools to safely identify and mitigate the risk. At this inspection, people receiving personal care did not have complex or high care needs, but did have risks associated with their care needs.

- We found risks were still not managed. In all three care plans, there was limited or no information to tell staff, what to do to reduce a person's exposure to risk. Speaking with staff showed they were not aware of how to manage risks such as slips or falls or what help a person needed to protect them from potential harm.
- One person was identified as an 'amber' risk for falls when being assisted with showering, yet there was no information that told staff, what to do. We checked the person's records and found they had fallen on at least six occasions. Where medical professional advice was given, there was no follow up action to ensure this had been completed. There was no falls log or consistent recording to show what measures had been taken to reduce the number of falls. The registered manager said this person could no longer be showered, yet records did not support this. Staff's understanding of showering and or washing this person was inconsistent in the absence of clear guidance to follow.
- Another person was identified as 'red' risk of falls when showering and bathing. Again, there was no information to tell staff what to do to reduce any known risks. Staff's knowledge of what, how and when to record daily checks was inconsistent and did not fully explain what support they had provided.

Preventing and controlling infection
- We could not be confident, safe practice promoted good infection control.
- We were not confident the management and senior staff team led by example, such as following social distancing rules. On three occasions during our visit, we saw four senior/management staff in the manager's office. No social distancing or wearing of face masks was observed.
- We were not assured care staff used PPE effectively and safely. People told us when staff supported them with care tasks, not all staff wore a face mask on every occasion. People did say, staff always wore gloves and an apron. A staff member confirmed this, "I don't always wear one" but could not explain why. We saw evidence this had been addressed in April 2021 although a staff member continued to tell us they did not always wear a face mask.

Learning lessons when things go wrong
- Improvement actions from the last inspection remained so the provider had not learnt from previous experiences to drive improvement. For example, this included a lack of understanding about what the regulated activity of personal care meant.

● Care plan and risk assessments continued to be incomplete with a lack of evidence to demonstrate how learning from incident and accidents prevented unnecessary exposure to risk.
● A system to monitor falls, incidents and accidents had been established, however this did not consistently record, the correct number of incidents. We found in people's daily care records, falls that had not been correctly logged, which did not feature within the overall analysis. This meant patterns or trends were not always obvious or correct.

We found no evidence that people had been harmed however the provider had failed to ensure safe practices were followed to monitor and manage individual risks related to people's care and to reduce unnecessary risks created through poor infection control practices. This demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People felt safe when supported by staff. Comments included, "I feel safe, they are all wonderful and do their level best" and "They are very caring so I feel safe."
●Staff had some understanding of abuse and how to keep people safe. They knew what action they needed to take if they had any suspicions or concerns people were at risk of harm or discrimination.
● The registered manager was not always clear what needed to be reported to us and the importance of keeping people safe and protected. They told us about one incident which they had not referred to us. The registered manager had investigated the matter but said this was an oversight.

Staffing and recruitment
● There were enough staff on the day of our visit to provide safe care.
● The registered manager said staff rotas ensured staff usually provided care to the same people.
● People told us staff were usually the same, they knew them well and they arrived at the times they wanted. One person said, "I get someone every day to wash and dress me. They (staff) know what they are doing. They make me laugh."

Using medicines safely
At this inspection, no one who received personal care, had staff to support them with their medicines. Therefore, we did not look at this in detail.
● The registered manager said medicines were checked in and out and records were completed to show medicines were given when required.
● Prior to the inspection visit, a service manager told us the provider was updating their medicines policy to further strengthen safe medicines practice.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has stayed the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Ensuring consent to care and treatment in line with law and guidance, assessing people's needs and choices; delivering care in line with standards, guidance and the law
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 Act 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 MCA.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority from the Court of Protection.

- Everyone receiving a regulated activity, had their own home and were not restricted in how they lived their lives. People said staff sought consent and involved them in their care. One person said, "Excellent, they all offer before you ask for anything."
- Where the provider had reason to question a person's capacity to understand information related to their care and support, this was followed but not always recorded. In one example, a family member had authority to make decisions for their relative through a lasting power of attorney.
- Care plans focussed on people being encouraged to make their own decisions on a day to day basis. Staff assumed people had capacity to make their own decisions and understood the importance of obtaining people's consent.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- All three people were able to make their own choices to seek health professional support. However, a staff member said on occasions, medical support was not followed up. They said following our inspection, improvements had begun to seek additional support from GP's or occupational therapists.
- We saw examples where some people had received paramedic support following a fall or incident. In some examples, we saw advice such as referrals to other health professionals or advice to promote fluids, had not been followed up. A lack of follow up had not had a negative impact on this person, but we recommend to the registered manager this was followed in a timely way to ensure any ongoing support continued to meet this person's needs. Before we left, the registered manager spoke with family members to follow this up.

Staff support: induction, training, skills and experience

● People thought staff were trained and knowledgeable to meet their needs. One person said, "Staff know exactly what I want and know how to do it."

● The provider's records showed staff training was refreshed although some gaps existed. Further training was being arranged to upskill staff. Some training had lapsed, but this was primarily due to the pandemic. Plans to reintroduce training had begun.

● Staff told us they were trained to meet people's physical, health and emotional needs.

Supporting people to eat and drink enough to maintain a balanced diet

● People were able to look after themselves and provided their own meals and drinks, with no help or support required.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has stayed 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

- Prior to our inspection, we received concerning information that staff were not being guided in who they should provide personal care to. Responses to those concerns from the provider and during our inspection, showed staff had provided personal care to people without a care plan. Limited guidance and support from the provider to prevent this or to provide clarity, had not taken place.
- Systems and processes were not used effectively to review and maintain oversight of the service being provided. This lack of oversight had potential to impact negatively on the quality of care people received. For example, effective falls management had failed to record each fall, incident forms were not always completed in line with provider's policies. The registered manager believed their falls analysis was accurate, but our evidence showed it was not. We found some falls relating to one person that resulted in paramedic attendance, were not recorded on incident forms and/or monthly falls analysis.
- Care plans and risk assessments were not changed and consideration to increased risk or additional measures had not been undertaken. These examples showed there was no culture of continuous learning.
- Systems and processes to identify, monitor and improve the service continued to fall short of meeting the regulations. There continued to be no formal audit process to record what had been checked and what actions had been taken. There was no evidence presented to us for audits we would expect to be completed, such as care plan quality, care reviews, daily records and call monitoring. When we asked the registered manager for examples of quality checks, the registered manager said, "If it's not written down it didn't happen. All the checks are in my head."
- The provider's systems and processes to maintain safe infection control practices were not robust to minimise the risks of cross infection.
- Where there were policies and procedures for governance, these did not support the regulatory requirements to maintain a robust and effective system. The service manager told us prior to our visit, some policies dated 2017 needed updating. An onsite service manager agreed a review of policies was needed to provide better guidance.

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

- We cannot be confident the above statement was understood by the registered manager or provider. We found when several incidents had occurred, there had been ineffective governance to review the incident

and learn lessons. Care plans had not been reviewed to provide up to date guidance. The poor review of incidents affected the provider's understanding of when things went wrong.
● During our visit, we lacked confidence in the manager's understanding of what their responsibilities were to ensure good systems of governance were followed. The registered manager told us since the last inspection, they had asked for support and guidance from the provider. This had not been provided sufficiently to drive and sustain improvements.
● The registered manager told us of a safeguarding incident that had not been reported to us in line with their legal responsibilities.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others;
● The regional manager said they had registered with Skills for Care, so they had regular updates on information, good practice and important updates regarding the pandemic.
● Internal communications through staff meetings kept managers and staff updated on latest guidance and best practice, although our evidence shows this was not always followed.

The registered provider was not responsible for the building. The registered manager had not ensured that the person responsible for the building and the safety of all people using the facilities including a dining room, modelled on a public restaurant principle, was adhering to the government's road map to limit social contact. The registered manager and a service manager agreed to review this.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Annual feedback survey had been completed and the registered manager compiled an analysis. Comments were positive and people praised the staff.
● Staff meetings provided an opportunity for staff to discuss and share ideas.
● Staff enjoyed working at Tiddington Court and felt able to raise concerns either to the registered manager, the provider and to us. During our inspection, the provider was investigating and following up actions from concerns brought to their attention.

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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider's policies and procedures to ensure the proper and safe management of risk was not consistently managed to keep people safe.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured robust quality systems or processes were fully effective to monitor the service appropriately, including people's safety.