CareTech Community Services Limited

# CareTech Community Services Limited - 19 Wheelwright Road

## Inspection report

19 Wheelwright Road
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Birmingham
West Midlands
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Tel: 01213504383

Date of inspection visit:
03 February 2020
05 February 2020
28 February 2020

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02 July 2020

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| Is the service safe? | Requires Improvement |
| Is the service effective? | Requires Improvement |
| Is the service caring? | Requires Improvement |
| Is the service responsive? | Requires Improvement |
| Is the service well-led? | Inadequate |

# Summary of findings

## Overall summary

About the service
CareTech Community Services Limited - 19 Wheelwright Road is a residential care home providing personal care to six people who are living with a learning disability or autism at the time of the inspection. The service can support up to six people.

The care home accommodates six people in one adapted building. Two people have their own flats and the four other people share communal living areas.

People's experience of using this service and what we found
The service had not always been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service did not always receive planned and co-ordinated person-centred support that was appropriate and inclusive of them.

The service did not consistently apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence. The outcomes for people did not fully reflect the principles and values of Registering the Right Support as people did not always have opportunity for meaningful activities, there was limited opportunity for independence and people did not have regular input into developing their care.

People did not always receive safe care. We found that safeguarding processes were not robust, and steps had not been taken to mitigate all risks to people. Staff were recruited safely and there were sufficient staff available to support people. People received their medicines safely and were protected from the risk of infection.

People did not always receive effective care. Staff training had not been planned or monitored to ensure all staff had the skills needed to carry out their work. Staff had not received support through consistent supervision. Whilst people were supported to eat meals of their choosing, we found the meal time experience could be further improved. People were supported to receive healthcare in line with their individual needs.

People were not consistently supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

People did not always receive care that was delivered with dignity and respect. Whilst we saw caring

interactions between staff and people there were also times where staff displayed a lack of understanding of people's individual needs. People had not always received appropriate support with behaviours that challenge.

People did not always receive responsive care. People had not had consistent opportunity for meaningful activities or inclusion in their community.

People had not received a service that was well-led. We found significant shortfalls in the monitoring of and systems within the service. We had reports of a poor culture within the service where some staff felt unable to raise concerns with the management 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 23 February 2019).

Why we inspected
The inspection was prompted in part due to concerns received about medication practice, poor and inappropriate use of restraint and restrictions on people's choices. A decision was made for us to inspect and examine those risks. We received further safeguarding concerns following the first two days of inspection so returned on the 28 February 2020 to examine those concerns.

We have found evidence that the provider needs to make improvements. Please see the safe, caring, responsive 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.

Enforcement
We have identified breaches in relation to providing safe care and protecting people from abuse, ensuring people are treated with dignity and respect, supporting people to receive person centred care, and the leadership and monitoring of the service at this inspection.

We raised our urgent concerns with the provider following the first two days of inspection and asked for information of how they intended to safeguard people living at the service. We continued to raise concerns with the provider following the third day of the inspection.

The provider has been responsive and open in their conversations with us and has shown a willingness to improve the failings we identified. We continue to be in close contact with the provider who is engaging with us.

We are mindful of the impact of 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 to keep people safe and to hold providers to account where it is necessary for us to do so.

Follow up
We will request an action plan 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.

## 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 effective?**

The service was not always effective.

Details are in our effective findings below.

**Requires Improvement**

**Is the service caring?**

The service was not always caring.

Details are in our caring findings below

**Requires Improvement**

**Is the service responsive?**

The service was not always responsive.

Details are in our responsive findings below.

**Requires Improvement**

**Is the service well-led?**

The service was not well-led.

Details are in our well-Led findings below.

**Inadequate**

# CareTech Community Services Limited - 19 Wheelwright 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 Care Act 2014.

Inspection team
One inspector carried out the first day of the inspection. Two inspectors returned on the second and third day to complete the inspection.

Service and service type
CareTech Community Services- 19 Wheelwright Road is a 'care home'. People in care homes receive accommodation and nursing or personal care 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.

The service had a manager registered with the Care Quality Commission. 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. The registered manager was not at work at the time of the inspection, so we spoke with the locality manager who was covering their absence.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and who work with this service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection-
We spoke with one person who used the service about their experience of the care provided. We spoke with twelve staff including care staff, the locality manager, operations manager and the operations director. We also spoke with a visiting healthcare professional.

We reviewed a range of records. This included three peoples care records and three medication records. We looked at six staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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

Systems and processes to safeguard people from the risk of abuse

- People were not always safeguarded from the risk of abuse. We found failings in the reporting and investigating of safeguarding concerns within the service.
- In one instance a safeguarding concern had not been raised and in another instance, there had been a delay in informing relevant partner agencies of safeguarding allegations. This placed people at risk of continued harm as systems in place were not sufficiently robust to protect people from the risk of abuse.
- We spoke with staff about safeguarding and whilst they understood how to recognise indicators of abuse one staff member we spoke with told us they did not feel confident that safeguarding concerns would be reported to relevant agencies.

A failure to have effective and robust systems in place to safeguard people 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).

Learning lessons when things go wrong

- There were systems in place for staff to report incidents and accidents that had happened relating to people. However, we found that these incident reports were not fully completed and did not always state what had happened before, during or after the incident. Due to the missing information a full analysis of the incident could not occur to reduce the risk of a similar incident occurring again.
- Some people living at the service self-harmed as a means of communicating. Where people had an injury as a result of one of these incidents, medical assistance was not always sought. This placed people at risk of harm.
- Incident reports were not analysed for themes and trends to identify and prevent reoccurrence of incidents. This placed people at risk of ongoing harm as risks had not been identified or mitigated against.

A failure to mitigate risks to people is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

Assessing risk, safety monitoring and management

- Some people living at the home displayed behaviour as a means of communicating. Whilst there were care plans in place that aimed to reduce the chance of the instances occurring, we found these care plans lacked detail and didn't describe all the behaviours that people used.
- Staff had some understanding of the risks associated with people's behaviour although staff described different approaches in supporting the same person. This did not support a consistent approach for the

person.
●One person we spoke with felt safe living at the home. They told us, "They look after me."
● People had the individual risks associated with their care identified and plans put in place to mitigate these.

Staffing and recruitment
● People living at the service received 1:1 support for the majority of the time. We observed that people received their 1:1 support during the inspection.
● At our last inspection we had assessed that staff were safely recruited. At this inspection we continued to find this to be the case. Staff informed us of the recruitment checks they had undertaken prior to commencing work at the service.

Using medicines safely
● People had received safe support with the administration of their medicines. We saw there were systems in place to check that people had received their medicines as prescribed.
● Whilst we were assured that people were currently receiving their medicines safely, one staff member informed us about past concerns relating to medicine management. We investigated these concerns further during the inspection and found one instance where a person's medicine had been stopped by the management of the service. We could not find any accompanying records that gave explanation for this occurrence including any records that health professionals had been contacted. We have asked the provider to look into these matters.

Preventing and controlling infection
● There were systems in place that supported good infection control standards. Staff had an understanding of how to ensure infection control was carried out through their work.
● Whilst we observed the home looked clean, we raised with the provider that certain areas required maintenance or redecoration. The provider has been addressing these areas following our inspection.

Requires Improvement

# 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 now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff informed us whilst they had received mandatory training, they felt that more training around people's individual needs would be beneficial to enable them to have a better understanding of people's individual conditions.
- There were systems in place that monitored the completion of training. We were informed that the current training completion was below what was expected by the provider. There had been no plan put in place to ensure staff completed the required training.
- We received mixed views from staff regarding the frequency of their supervision. Some staff were happy with the frequency whereas others informed us they had not received supervision. We checked staff records and found a number of staff had not received supervision for a substantial amount of time. For example, one staff member had not received a supervision for nearly a year. Receiving regular supervision enables staff to have support and guidance on their roles .

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's care plans contained an assessment of their needs. These assessments included consideration of people's ethnicity and spiritual needs.

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

- People had been supported to eat and drink meals of their choosing. We saw staff asking people what they would like to eat.
- We found the meal time experience could be improved. One person sat at a windowsill to eat their meal. We asked for an explanation, but this could not be provided. In another example a person with visual impairment was given food without staff explaining to them what they were about to eat . This did not show that staff had always had consideration of peoples individual needs or demonstrate that staff had involved people in choices about their care.

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

- The locality manager provided examples of when they had worked with other professionals to support people's individual needs. This included internal behaviour support teams and speech and language therapists.
- We saw people had health action plans that could be transported to medical appointments. These specified how people liked to be supported in an easy read format to enable health professionals to

understand people's needs quicker.
● People had access to routine healthcare in line with their needs. This included specialist support from psychiatrists and behaviour support teams. We saw that people also had visits from the chiropodist had eye tests and saw their GP as and when needed.
● We saw that people had the opportunity to attend a dentist for oral healthcare needs. There were specific care plans around this area of people's care.

Adapting service, design, decoration to meet people's needs
● We found that the service was in need of re-decoration. Communal areas of the home were sparsely decorated with no features of interest for people to view.
● There were communal areas of the home that we saw people regularly accessing. They were of a large enough size for people to spend time together should they wish.

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). 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 and were being met.

● Staff could explain how they offered people choices and sought their consent. Staff understood the principles of the MCA.
● Whilst we found that day to day practice had considered and met the principles of the MCA we found that recordings of assessments needed some improvement. For example, records of assessments of people's capacity to make decisions were not decision specific.
● Where people had been deemed as lacking capacity to make a decision these were not consistently followed with a 'best interests' meeting.
● Most of the people living at the home had a DoLS authorisation in place. There were systems in place to ensure these were renewed as and when needed.

Requires Improvement

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity;
Respecting and promoting people's privacy, dignity and independence

● We found serious concerns regarding the living conditions for one person which did not uphold their rights to privacy and dignity. The person did not have a toilet seat nor a door on their bathroom. There was no means to cover the windows should the person want privacy. We were informed the reason for the sparsity in this person's room was related to behaviour they displayed. Records we viewed did not confirm that the behaviour described to us was a known behaviour for the person. We raised our concerns with the provider who took immediate action to improve this person's living conditions . The provider has also reviewed and updated this person's records.

● We had concerns raised with us by staff members regarding incidents of shouting that had occurred between staff members. At times these incidents had occurred in front of people living at the home. Whilst these incidents had been investigated and action had been taken as a result of these, consideration had not been always been given to the impact these incidents may have had on people living at the home.

● Staff did not consistently show due respect for the people they were supporting. For example, on one occasion we saw a staff member using a concerning approach whereby the staff member tried to lead a person away from an area with the promise of food. This did not show due respect for the person's dignity or show they were treated as equals. In another example a staff member restricted a person from accessing the stair way, by blocking the stair way, despite the person saying this was what they wanted to do. We raised our concerns with the provider who took immediate action to address this.

A failure to ensure people are treated with dignity and respect is a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

● We did also observe positive interactions between staff and people. Some staff had a calm and supportive approach and spoke with people appropriately.

● We saw staff promoted people's independence at times, for example, when people did their laundry. However, one person's independence had been restricted at times due to them not knowing the door codes to access areas of the home such as the kitchen. We raised this with the operations director who agreed to investigate this.

● Staff were able to tell us how they ensured people had their privacy respected.

● All the staff we spoke with told us they enjoyed their role of supporting people. One staff member said, "We are here to make sure people have a good quality of life." Some staff members had worked at the service for a number of years and had got to know the people they supported well.

Supporting people to express their views and be involved in making decisions about their care

● Whilst some elements of care plans showed us that people's preferences had been considered, it was unclear the extent to which people had been involved in expressing decisions about their care.

Requires Improvement

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- At times staff's communication with people showed a lack of understanding that their behaviour was a form of communication. In one example staff consistently used the word 'no' in an attempt to re-direct a person from doing something without explanation.
- Whilst care records had been reviewed, and we saw at times that families had contributed to these reviews, there were limited opportunities for people to contribute into reviews about their care. Good practice is that person centred reviews are held to enable the person to be at the centre of their review. These had not occurred at the service.
- Behaviour support plans did not provide staff with clear guidance on people's behavioural needs and in some instances did not include all the behaviours that a person displayed.
- Whilst staff knew people's needs well this was not always reflected in people's care plans . People had not consistently been supported to have their individual needs met.
- Following our inspection the provider has taken steps to implement changes around the support people receive in relation to their behavioural needs and has been working towards people being able to review their care.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Most of the people living at the service had little or no verbal communication. Staff were able to tell us different ways people living at the home communicated.
- People's care plans detailed how people communicated and stated the different communication aids that were available to support people's communication. However, we found that these communication aids were not consistently used with people.
- Whilst people's care plans stated the different methods people used for communication, they were not complete, and we found staff were using different ways of communicating with people or had not fully explored people's communication style. In one example a person had approached us trying to say a word. When we asked staff for explanation of what the person was saying staff were unsure . People had not received consistent support to have their individual needs met.

A failure to ensure people receive care that is centred on their needs is a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Whilst people did partake in some activities of interest this did not happen on a regular basis. Recordings of activities undertaken demonstrated that people had not had consistent opportunity to take part in activities they enjoyed. For example, one person's care plan specified activities of interest outside of the service. Over a period of two weeks this person had not regularly participated in these activities despite them receiving 1:1 support.

● We spoke with one person who had been supported to take part in activities they enjoyed. Staff informed us of a college course the person was undertaking and of employment the person had secured.

● Some people living at the service had an advocate. Advocates support people by being an impartial person who can speak for a person who may not be able to speak for themselves.

Improving care quality in response to complaints or concerns

● We saw that complaints that had been raised were investigated in line with the provider's policy .

End of life care and support

● No one at the service was receiving end of life care at the time of the inspection. There was no information recorded about people's end of life wishes and although no one was receiving end of life care, this would be important to consider should there be an unexpected death.

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 Good. At this inspection this key question has now 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 .

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

- Some of the staff we spoke with told us they felt unable to raise concerns about the culture of the service and the conduct of some staff members. They described an oppressive culture that was not open and transparent.
- A poor culture at the service had resulted in a lack of person centred care for people. Monitoring systems in place had failed to consider the culture at the service. This included staff culture and a culture of a lack of person centred care for the people living at the service.

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

- Whilst there were quality monitoring systems in place we found significant shortfalls in their effectiveness and they had failed to identify the shortcomings we found during our inspection process.
- Systems had failed to identify and mitigate risk where people had self- injurious behaviours.
- Provider processes had failed to identify and protect one person's dignity and safety in their living conditions.
- The governance systems had not been used effectively to identify that people were not consistently receiving effective support with behaviours that challenge.
- Systems had failed to identify that people did not have consistent opportunity for meaningful activities.
- Monitoring systems had failed to identify that safeguarding processes were not robust.
- Systems had failed to identify that staff had not received consistent support and supervision.
- Systems had failed to identify potential risk factors in a staff members employment.
- We raised our urgent concerns with the provider and the local authority in order to safeguard people living at the service.

A failure to implement robust governance systems is a breach of Regulation 17 (Good Governance) 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

- The provider has been open and transparent with us throughout the inspection process. The provider has shown a keen willingness and desire to improve the service.

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

● The registered manager had sought feedback from family members about the quality of the service provided. We saw two responses had been returned from the survey and both showed a good satisfaction with the service provided.

● Staff meetings had started to occur more frequently following our inspection to enable staff to have input into the development of the service.

Working in partnership with others

● The locality manager informed us of ways they worked with other professionals such as speech and language therapists, GPs, advocates and psychiatrists to support people's individual needs.

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 9 HSCA RA Regulations 2014 Person-centred care<br><br>The provider had failed to ensure all people received care that was centred on their needs and preferences. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>The provider had failed to ensure people were treated with dignity and respect. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider had failed to mitigate risks to people's care |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider had failed to ensure robust and effective safeguarding processes were in place. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to ensure robust and |

effective governance systems were in place.