Michael Batt Foundation

Michael Batt Foundation

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

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
Michael Batt Foundation is a residential care home that provides personal care and support for up to 3 people with a learning disability, autism or who have complex needs associated with their mental health. At the time of the inspection there were 2 people living at the service.

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

Right Support: The Model of Care and setting within the service did not maximise people's choice, control and independence. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People were not protected from the risk of harm as systems and process did not provide staff with all the information needed to meet people's needs safely. There were insufficient arrangements in place to ensure people had access to appropriate space. The premises did not always meet people's support needs.

Right Care: Risks such as those associated with people's complex health and / or medical needs were not adequately assessed by the provider. Staff did not have access to all the information they needed to meet people's needs safely.

People did not always have their human rights upheld, and the service did not always promote equality. Staff and people were subject to unsafe staffing arrangements.

Right Culture: Restrictive practices, poor application and understanding of the Mental Capacity (MCA), a lack of openness and transparency and inadequate governance and oversight had helped to create a 'closed culture' at The Michael Batt Foundation.

A 'closed culture' is a poor culture that can lead to harm, including human rights breaches such as abuse. In these services, people are more likely to be at risk of deliberate or unintentional harm. It was evident from a review of the data and information held by the provider, and our findings throughout our inspection that staff did not receive regular, effective supervision and support.

The provider was aware of their regulatory responsibilities such as submitting statutory notifications but

failed to carry this out. The findings of our inspection identified a culture that was not based on learning. This meant that when things had gone wrong, the potential for re-occurrence was inevitable because there was no action taken to review, investigate and reflect on incidents.

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 4 January 2018)

Why we inspected
We undertook a focused inspection to review the key questions of safe and well-led only. However, further concerns and risks were identified so a decision was made to include the key question of effective.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

Enforcement
We have identified breaches in relation to safe care and treatment, safeguarding people from abuse, consent, premises, person centred care, staffing, notifications of other incidents and governance.

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

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

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

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The 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 effective?

Inadequate

The service was not effective.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our safe findings below.

Michael Batt Foundation

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector.

Service and service type
Michael Batt 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. Michael Batt is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post.

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 professionals who work with the service. 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 used all this information to plan our inspection.

During the inspection
We spoke with a director and the new manager and 2 care staff.

We reviewed a range of records. This included 2 people's care records We looked at 6 staff files in relation to recruitment. A variety of records relating to the management of the service, including medication records, accidents and incidents and training records. After the inspection We continued to seek clarification from the provider to validate evidence found.

Inadequate

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 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

- There was an absence of safeguarding systems and processes. When we raised our concerns with the manager, they acknowledged that safeguarding systems were not in place despite the provider having policies and procedures in place.
- When we requested evidence of a safeguarding system, for example an action log, we were informed that no system was in place.
- Staff were able to describe the actions they could take if they had safeguarding concerns for the people they supported. However, records showed appropriate action had not been taken. For example, one person's care plan guided staff to make safeguarding referrals should their health conditions worsen. However, staff and the provider failed to take this action. This placed the person at risk of harm.

This meant the provider failed to operate an effective safeguarding system that reported, recorded, acted on and investigated concerns. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- One person was assessed as being at high risk of choking. However, the persons care records were inconsistent and it was unclear as to whether they were receiving the dietary requirements and food consistency's set out within their care plan. The lack of consistent guidance for staff placed the person at further risk.
- One person was living with diabetes. The persons care records contained no information about how staff should support the person with their diabetes. For example, there was no information relating to possible complications of poorly controlled diabetes and what routine health checks the person may need to keep them safe and well.
- One person was living with epilepsy. The provider did not ensure appropriate information was shared with specialist healthcare professionals as per the guidance within the persons care records. This placed the person at risk of not receiving appropriate timely treatment.

The failure to provide safe care and treatment for people with epilepsy and diabetes, and the failure to reduce the risks associated with choking put people at an increased risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- One person had medicines prescribed to be given when required. Staff did not always have guidance available to help them make consistent decisions about when these medicines might be needed. When

guidance was in place, it was not person-centred and did not describe a person's individual needs.
● The provider did not capture and record staff competencies, in relation to the administration of medicines. This meant that medicines were not always managed safely and in line with the National Institute for Health and Care Excellence (NICE) guidance 'Managing medicines for adults receiving social care in the community'. Therefore, we were not assured that medicines were managed safely.
● People had handwritten medicine administration records. These records were not checked and counter signed to ensure they were accurate. This is not in line with National Institute for Health and Care Excellence (NICE) guidance on 'Managing medicines in care homes' and increased the risk of people not receiving their medicines as prescribed.

We found no evidence people had been harmed. However, the provider had failed to ensure the proper and safe management of medicines. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Where staff were required to work alone with people, the provider had not taken adequate measures to reduce the risks associated with lone working.
● People were placed at the risk of not receiving adequate care as staffing arrangements during the day were not sufficient to meet people's needs safely. Records confirmed, and staff told us, one person was commissioned to have support from 1 member of staff. Our observations identified this person was receiving their commissioned support, however, the staff member was working in isolation. This placed the person at risk if the staff member experienced and accident or untoward event.

The failure to deploy staff effectively was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since we undertook an inspection of the providers other service in Plymouth and identified systemic failings in the quality of care provided. The provider had employed a new manager and sought support from a consultancy firm. Whilst we observed that some steps had been taken to address systemic concerns relating to the safety and quality of the services provided by this provider. The new leadership team had not had time to fully embed changes and start to maximise the outcomes for people who used the service.
● People were protected against the employment of unsuitable staff. We looked at pre-employment checks for 3 members of staff and found they had been completed appropriately.

Preventing and controlling infection
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. The premises and equipment were not always clean.
● The upstairs bathroom included a handrail that had rust forming on it and bath and handwashing basins seals were heavily moulded. We observed areas were grouting for tilling was incomplete which could harbor bacteria and present an infection control risk.
● Because of these findings we could not be assured that the provider was supporting people living at the service to minimise the spread of infection.
● Because of these findings we could not be assured the provider was making sure infection outbreaks can be effectively prevented or managed.

The failure to ensure people were always protected from the risk of infection, was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
The service could support visits. Protocols were in place should there be any disruption due to COVID-19 outbreaks.

Learning lessons when things go wrong
● Systems were either not in place or robust enough to demonstrate accidents and incidents were effectively monitored and reviewed. For example, there was no system to analyse and review accidents and incidents.
● The findings of our inspection identified a culture that was not based on learning. We saw evidence where a person had experienced multiple falls. However, because of the ineffective system to monitor and review these incidents the provider had failed to take reasonable steps to prevent reoccurrence.

The failure to take appropriate action to mitigate harm and reduce the possibility of reoccurrence of incidents was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes

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 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 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● We reviewed care notes for 1 person who had an authorisation in place to deprive them of their liberty in 2018. Care records confirmed that the authorisation had expired in 2020. The new leadership team had taken steps to address this. However, this person had been unlawfully deprived of their liberty for 3 years. This meant there was no legal basis or framework in place to support these restrictions during this time. This failure meant the persons human rights were not always upheld.
● A decision had been made to install a video monitoring system for one person who was living with epilepsy. The provider had failed to ensure the appropriate authorisation was in place to use surveillance monitoring.

Acting unlawfully by applying restrictions to deprive people of their liberties whilst receiving care without authority, was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● There was a systemic lack of understanding in relation to the roles and responsibilities held by the provider and staff in relation to MCA. For example, the staff and previous leadership team had relied on external professionals to carryout assessments of people's capacity to consent. The failure of the provider to

act in accordance with the requirements of the MCA and associated code of practice, placed people at risk of unnecessary delays in appropriate consent to care being sought.
● Where monitoring equipment had been put in place the provider has failed to follow the best interest process to ensure actions taken were the least restrictive and in people's best interests.

The failure to assess people's capacity and record best interest decisions risked compromising people's rights. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● We reviewed staff training records against peoples care records and identified staff did not always have the training, competence, skills and experience to meet people's needs safely.
● It was evident from a review of the data and information held by the provider, and our findings throughout our inspection, that staff did not receive regular, effective supervision and support from the management team. The absence of a regular support mechanism meant staff were not fully empowered to carry out their roles and responsibilities and deliver effective good quality care.

The failure to provide adequate support and training to staff in order to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● There was a reliance, from the previous leadership team, on external professionals to carryout assessments of people's needs and subsequent reviews. There was a lack of understanding of how to deliver care in line with standards and access best practice guidance, for example in relation to MCA and medicines management.
● The Michael Batt Foundation did not carry out collaborative assessments of people's needs to ensure their needs could be met. People did not always have choice in how they spent their time and received support. This meant the service had not taken adequate steps to ensure the needs of people entering the service could be met.

The failure to carry out adequate assessments and reviews of peoples care needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were satisfied that the new leadership team had recognised this and were taking the necessary action to address this. However, these shortfalls had not been recognised by the provider until we undertook an inspection of the providers other service in Plymouth and identified systemic failings in the quality of care provided by this provider.

Adapting service, design, decoration to meet people's needs
● Michael Batt was a large building set over two floors. The service did not have a homely feel and we noted areas throughout the service were in disrepair. For example, damaged flooring and skirting boards.
●The front door to The Michael Batt foundation had not been adapted to support people in wheelchairs accessing and leaving the service.
● There was an absence of environmental monitoring and maintenance checks by the provider to ensure the service was suitable for its intended use of supporting people with complex care needs.

The failure to ensure the service was clean, suitable for the intended purpose and well maintained was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The flooring in the kitchen area was uneven and presented a potential falls risk to 1 person.
Another person could use a ramp situated in the garden to access and leave the service. However, the street adjoining the service was cobbled and presented a risk to the person and any staff who were supporting them. The service is not responsible for the cobbled surface of the street outside of the service. However the provider had not considered the risks posed by the cobbles and/or taken suitable action to reduce this risk.

The failure to mitigate the risks associated with people's care was a of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care, supporting people to live healthier lives, access healthcare services and support
● The service supported people to attend reviews and appointments with healthcare services. For example, one person was supported to attend an optician appointment with a specialist. However, despite people being supported to attend appointments and reviews from healthcare professionals, the service failed to ensure these reviews formed part of an internal care plan review process.
● The provider did not ensure appropriate information was shared with specialist healthcare professionals as per the guidance within people's care records. This placed people at risk of not receiving appropriate timely treatment.

Supporting people to eat and drink enough to maintain a balanced diet
● Care records indicated that people had a choice over what they wanted to eat. However, due to our findings in relation to diabetes and choking risks we could not be assured that peoples nutritional needs were always being met.

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 our last inspection we rated this key question Good. At this inspection the rating has changed 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; Continuous learning and improving care

- At this inspection, we found an absence of systems and processes to assess and monitor the quality and safety of the service provided to people and a failure to ensure compliance with regulations.
- Governance processes were not effective in keeping people safe, protecting people's rights and providing good quality care and support. The provider failed to operate appropriate monitoring and auditing systems to effectively manage the service and keep service users' safe from harm.
- Poor decision making potentially placed people at risk of harm. For example, in relation to staffing and risk management. The provider was aware of their regulatory responsibilities such as submitting statutory notifications but failed to carry this out. This meant people were at risk of living in a service where there was inadequate leadership and regulatory requirements were not being met, as required by law.
- The provider failed to ensure there were robust systems and processes in place to protect service users and staff from untoward risks associated with their environment.
- The providers systems and processes failed to identify peoples care records did not provide adequate guidance to staff as to how to meet people's individual risks and health needs.
- The providers systems and processes failed to identify people were not always supported to make decisions about their care and treatment in line with the principles of The Mental Capacity Act 2005 (MCA).

The lack of effective governance and oversight of the service placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Services that provide health and social care to people are required to inform the Care Quality Commission (CQC), of important events that happen in the service. The provider was aware of their responsibilities, however had failed to inform CQC about reportable events.

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

- The providers poor decision making in relation to restrictive practices, Mental Capacity Act and person centred care helped to reinforce a closed culture, which increased peoples dependence on the provider and staff who had limited understanding of how to support people in accordance with the Health and Social Care Act 2008 and Right support, right care, right culture, which is statutory guidance issued by The Care Quality Commission (CQC).
- We expect providers of learning disabilities services to have regard to this guidance, in order to maximise

choice, control and independence of people using their services. The provider was unable to demonstrate any regards for this statutory guidance.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics, working in partnership with others
● Staff told us they could access informal feedback mechanisms such as an 'open door policy'. However, because of our findings in relation to staff supervision and support we could not be assured that this approach was effective in acting on staff feedback with a view to developing the service.
● The provider was unable to demonstrate how they sought and acted on feedback from people using the service.
● Because of our findings in relation to the safe and effective sections of this report we could not be assured that partnership working was fully embedded and recognised as a norm within the services provisions.

The provider had not ensured that feedback from people was sought and the quality and safety of the service had been adequately assessed, monitored or improved to ensure it met with regulatory requirements and best practice guidance. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Throughout this inspection the new leadership team acted with honesty and transparency. Whilst we observed that some steps had been taken to address systemic concerns relating to the safety and quality of the service, the new leadership team had not had time to fully embed changes and start to maximise the outcomes for people who used the service.

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 CQC sets out specific requirements that providers must follow when things go wrong with care and treatment. This includes informing people and their relatives about the incident, providing reasonable support, providing truthful information and an apology when things go wrong, and taking appropriate action to prevent reoccurrence.
● The registered provider understood their responsibility under the duty of candour to be open and honest when things went wrong. However, due to the findings of the inspection we could not be satisfied that the correct procedures associated with duty of candour would be actioned and followed through.

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 18 Registration Regulations 2009 Notifications of other incidents Failure to inform CQC of notifiable events.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Failure to carry out adequate assessments and reviews of peoples care needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Failure to assess people's capacity and record best interests decisions.

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 Acting unlawfully and applying restrictions to deprive people of their liberties whilst receiving care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Failure to ensure the service was clean, suitable for the intended purpose and well maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The failure to provide adequate support and training to staff, and failure to deploy staff effectively.

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 12 HSCA RA Regulations 2014 Safe care and treatment Failure to provide safe care and treatment for people.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The lack of effective governance and oversight of the service placed people at risk of harm.

The enforcement action we took:

Warning Notice