Life Opportunities Trust

Life Opportunities Trust - 15 Rose Vale

Inspection report

15 Rosevale
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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service

Life Opportunities Trust - 15 Rose Vale is a care home providing accommodation for up to eight people with a learning disability or autism, including older people, some of whom are living with dementia and or a physical disability. At the time of the inspection there were six people living at the home.

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

Since the last inspection, there have been two different managers in post. The current registered manager is on a leave of absence, so the home was being managed by a third and interim manager.

Training relating to infection control and COVID-19 had been delivered. However, staff did not feel confident in their knowledge. In addition, we saw staff were wearing long sleeves which did not allow for the 'bare below the elbow' rule for effective handwashing. We also found that staff removed their masks to eat and drink with people. This had not been risk assessed or determined as to if it was necessary, even though staff members had tested positive for COVID-19.

Staff training, supervision and support had been lacking at the last inspection. Staff told us this had started to improve with the interim manager in post. Staff hoped they would stay at the service.

The environment had not improved. The refurbishment plan had not been completed due to delays caused with the pandemic. The interim manager and the provider were aware of the improvements that were required and were focused on making those improvements.

The recruitment process was managed by head office and as a result there was limited information held in the home about new staff starting. We found that the management of the recruitment process for staff needed to be more robust.

Governance systems needed to monitor and identify concerns had been developed however it was too early to tell if these had been effective as due to the pandemic and the number of changes to the manager of the home. Audits for areas such as infection control, care plans and medicines were completed. However, the medicines audit needed further development to ensure it identified shortfalls such as recording gaps.

People told us they felt safe and that staff were kind, they liked them and liked living at the service. Incident, events and unexplained injuries were recorded and investigated. Where needed, incidents were reported appropriately.

We were told that things at Life Opportunities Trust - 15 Rose Vale had improved with the interim manager in post. They were working to implement training, systems and guidance to help address previous concerns.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, 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 providing support to people with a learning disability and/or autistic people.

The service was able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

People spent their day in a way they chose, for example, one person wanted to stay in bed a bit later so staff didn't disturb them. People told us they could make their own choices about eating and daily routines, people were able to get out to the places they enjoyed prior to the recent lockdown and relationships were supported. Staff had developed relationships with people, and we saw people were treated as equals.

Rating at last inspection
The last rating for this service was requires improvement (published 12 February 2020) and there were multiple breaches of regulation. The provider sent us an action plan stating how they would make the required improvements.

Why we inspected
CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

We undertook a targeted inspection to follow up on the concerns we had at the last inspection and specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about the care people were receiving. A decision was made for us to inspect and examine those risks.

We found no evidence during this inspection that people were at risk of harm from these concerns.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

Please see the safe section of this full report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Life Opportunities Trust - 15 Rose Vale on our website at www.cqc.org.uk.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question Requires Improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question Requires Improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Life Opportunities Trust - 15 Rose Vale

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check whether the provider had made the required improvements following the last inspection. We will assess all of the key question at the next comprehensive inspection of the service.

Inspection team
This inspection was undertaken by one inspector.

Service and service type
Life Opportunities Trust - 15 Rose Vale 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 who was applying to be 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. However, they were absent at the time of the inspection and the home was managed by an interim manager who had been in post for three weeks.

Notice of inspection
We gave five minutes notice so we could clarify the services COVID-19 Personal Protective Equipment (PPE) practice for visiting professionals and identify persons who were shielding so we could respond accordingly.

What we did before 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 did not request a 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. We had requested information from the provider prior to the inspection and this information was used as part of the inspection plan.

During the inspection
We spoke with four members of staff including the interim manager. We spoke with two people who used the service and received feedback from two relatives. We contacted the local authority for their feedback. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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

Inspected but not rated

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to explore the specific concerns we had about Rosevale. We will assess all of the key question at the next comprehensive inspection of the service.

Preventing and controlling infection

• Guidance for hand washing, personal protective equipment and infection control was displayed in the service. Staff had access to personal protective equipment which we observed staff wearing appropriately in most cases. However, we did note staff at times pulled their masks down to drink and we were told that they ate meals with people. We discussed this with the interim manager and asked that they check their COVID-19 policy to ensure this was appropriate. We asked that they considered if accompanying risk assessments and management plans were needed should people need staff to sit with them and eat.

• Staff told us they had not received training for COVID-19. When asked how do they know what to do, one staff member told us, "From what I have seen online and in the news." The interim manager told us that staff had received infection control training. We requested a copy of the course content. This showed staff had attended infection control training, it was not clear if everyone's training had included COVID-19 training. The interim manager had staff booked on additional training.

• We noted that some staff wore long sleeves which did not follow the bare below the elbow rule to allow effective hand washing and infection control.

• Staff told us that agency staff used in the home had at times varied. We spoke with the interim manager who told us that they had asked the agency for consistent staff to reduce the risk of cross infection. We were also told that new staff were not expected to have a COVID-19 test before starting at the home. The interim manager told us they were trying to address this as a new staff member, now isolating, had tested positive.

• We were told on arrival that two staff had recently tested positive however this had not prompted the management team or provider to ensure effective infection control measures were consistently used. Following the inspection, we were told a third staff member had tested positive and all tests for people and staff had been redone. The results for these tests were negative.

We recommend that infection control measures and staff competency be reviewed to ensure the requirements are consistently maintained.

• The interim manager told us that family and friend visits to the home had been happening outside prior to the recently imposed lockdown. One relative told us that a staff member had taken their family member to visit them ahead of lockdown as they were unable to travel.

• There was a winter contingency plan should the pandemic impact on the home going forward. This set out plans on staffing and supporting people's safety.

Using medicines safely
• At the last inspection we found that medicines were managed safely. At this inspection we found that systems were not always robust.
• Records were not accurately maintained for boxed medicines prescribed on a when required basis. We found that quantities of medicines, such as Paracetamol, were not always recorded on medicine records. As a result, it was not possible to effectively audit these medicines.
• Medicine audits were completed but the last audit was completed in September 2020 and the records did not ask the auditor to check boxed medicines were recorded correctly or dated when opened.
• A sample of daily medicines checked showed that they were accurate and they were held securely.

Assessing risk, safety monitoring and management
• People told us they felt safe. Relatives also told us they felt people were safe. One person said, "I'm safe, I like it here."
• Staff told us that the interim manager was frequently around the home ensuring staff were working safely. However, staff told us that the manager, who had applied to be registered, was often in their office not providing oversight. Staff felt the interim manager provided more assurances.
• People had individual risk assessments. However, reviewing of these was not always consistent. There was ongoing work to develop and update care plans. Staff did know people well so were able to support them safely and new staff shadowed experienced staff.

Systems and processes to safeguard people from the risk of abuse
• At our last inspection we found that systems to monitor, report and investigate unexplained injuries were not robust.
• At this inspection we found that systems in place recorded unexplained injuries and a member of the management team completed an investigation. Safeguarding incidents were reported to us when needed and to the local authority safeguarding team.
• Staff were aware of what signs of abuse to look out for and how to report any concerns they had within the home. They were confident that the interim manager would act on any concerns raised. However, not all staff were clear on how to report concerns outside of the organisation.

Staffing and recruitment
• At our last inspection the provider had failed to ensure that sufficient checks were carried out before staff were employed.
• At the last inspection we found that the recruitment process was not always robust and staff had not consistently received the required training and support for their roles. This was a breach of Regulation 19 [Fit and proper persons employed].

While we found the management of the recruitment process was not fully effective, there was enough improvement and the service was no longer in breach of Regulation 19.

• At this inspection we found that the management of recruitment, identifying employment history gaps and following this up had not fully been addressed. We checked the files of two newly appointed staff. We found that one file only included one reference and the second file was missing most of the recruitment information. The interim manager told us that head office completed the recruitment process. We reviewed this information when it was sent to us from head office. We found that while some information was in place, it wasn't consistent or followed up before staff started work at the service.
• People told us they staff were around when they needed them. Staff told us that staffing levels had improved with recruiting that had recently been completed.
• Staff were around and were responding to people's requests when needed.

• Staff told us training and supervisions were ongoing with the support of the interim manager. The training and supervision matrix showed that progress was being made, however this remained a top priority for the interim manager. They said, "To run a service properly, staff must be trained."

Learning lessons when things go wrong
•Staff meetings included information about events and updates that staff needed to be aware of. Staff felt the interim manager was keeping them informed.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to explore the specific concerns we had about Rosevale. We will assess all of the key question at the next comprehensive inspection of the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people and Engaging and involving people using the service, the public and staff, fully considering their equality characteristics, Continuous learning and improving care

- At the last inspection we found that staff morale was low, and the management team did not engage with people or staff. Since the last inspection there has been three changes of manager. Staff feedback about the new interim manager was positive.
- The interim manager and the deputy manager were working on addressing shortfalls in the home and learning from previous concerns. Systems were being put in place to reduce the risk of reoccurrences.

At our last inspection concerns were found that complaints were not always fully responded to. This was a breach of Regulation 16 [Complaints] of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There was enough improvement made at this inspection and the provider was no longer in breach of regulation 16.

- There was a log of any complaints and a record of responding and monitoring these. Relatives told us complaints were responded to.
- Staff told us that the interim manager was visible in the home, responsive to issues, checking how things were and guiding staff. One staff member said, "I really like [interim manager], she listens, I hope she stays."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements and 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

- At the last inspection the registered manager did not adhere to the duty of candour as they had failed to be open, honest, and apologise to people when things went wrong. This was a breach of Regulation 20 [Duty of Candour]. At this inspection we found that the interim manager was keeping people and their relatives informed about events and incidents in the home. They were reporting to the appropriate agencies. One relative said, "They call me when they need to."

There was enough improvement made at this inspection and the provider was no longer in breach of

regulation 20.

At the last inspection quality assurance systems were not used effectively. This was a breach of Regulation 17[Good Governance]. At this inspection we found that some systems were now in place, however due to changes of management, this had not always been used robustly and were still a work in progress.

There was not enough improvement made at this inspection and the provider was still in breach of Regulation 17.

● The interim manager was working through issues in the home but was not yet fully up to speed about the outstanding issues. However, audits and checks were being completed. Improvements needed were added to an action plan which the interim manager and deputy manager were working through.
● There was a service improvement plan which included the areas found to be needing improvement. Some of these areas had been an issue at the last inspection and progress was slow. This was in part due to the pandemic and in part due to the changes in manager. In addition, the home was in need of redecoration and refurbishment and this had not been completed. Carpets were stained and walls were chipped and scuffed. The provider was in discussions with the local authority about support with funding to address these areas.
● The action plans developed within the home were basic. They did not detail how actions would be achieved, what resources were needed and who would be responsible. The interim manager told us this was an area for development and they, along with the deputy manager were making this a priority. The interim manager told us, "We have a long list but I am going to put my all into it."
● Care plans had been identified as needing to be updated and for reviews to be completed. We found that work had started on this. The interim manager said, "We need to work on making them more person centred and discuss them with people." However, we noted that staff all knew people well, including their likes and dislikes and how people communicated their needs.
● The interim manager provided guidance and leadership for staff. Staff told us that they found the interim manager supportive, and they listened to people and staff.

Working in partnership with others
● The interim manager was in contact the local authority and engaging with CQC to support the inspection and help identify any shortfalls.
● During the pandemic the provider had been working with Public Health England to help ensure they were up to date with guidance.
● The interim manager was open to feedback and wanted to use this to improve and develop the service further. They told us, "We all just want to make everyone's life better."

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured the stability of governance systems and leadership in the home. Some work had been done but this had not fully addressed the shortfalls.