Dignus Healthcare Limited

Chance Drive

Inspection report

1 Chance Drive
Smethwick
B66 1TT

Tel: 01213575049
Website: www.dignushealthcare.com

Date of inspection visit:
09 March 2021
10 March 2021
11 March 2021
15 March 2021
16 March 2021

Date of publication:
27 August 2021

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Chance Drive is a residential care home providing care and support to younger adults, people with a diagnosis of learning disabilities or autistic spectrum disorder and people with a mental health diagnosis. At the time of the inspection eight people were receiving support. The service can support up to eight people.

Chance Drive accommodates people across two independent flats and a communal home with six bedrooms, each of which has adapted facilities.

People's experience of using this service and what we found
People did not always feel safe. Ongoing risks to people had not always been assessed or mitigated. Allegations of abuse had not consistently been reported to local authority safeguarding teams.

Staff practices were not always person centred. There was poor record keeping around management of incidents. Care plans and risk assessments were not always updated.

Where concerns had been raised, these had not always been acted on. People and relatives had not been given the opportunity to provide formal feedback. Incidents had not been notified to CQC in line with legal requirements.

Systems and processes had failed to identified shortfalls we found on inspection. These included safeguarding, risk management and incident management.

There were good infection control practices in relation to COVID-19.

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 statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This service was not always able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. Care was not always person centred to promote dignity and human rights. The behaviours of leaders and care staff did not always ensure people using services lead confident, inclusive and empowered lives. We raised concerns with the operations manager who took immediate actions. Please see safe and well-led sections of the report.

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 14 August 2019).

Why we inspected
We received concerns in relation to safeguarding, incident management and the management of the home. As a result, we undertook a focused inspection to review the key questions of safe 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 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.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Chance Drive 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 breaches in relation to safe care and treatment, safeguarding, failure to notify CQC and governance at this inspection. Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Chance Drive

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.

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 completed by two inspectors and an assistant inspector. The inspection was carried out over five days. One inspector and an assistant inspector spent one day in the home. Two inspectors made telephone calls and reviewed evidence across all five days.

Service and service type
Chance Drive 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.

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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to

send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We met with four people who used the service. We received feedback either verbally or in written format from two people. We spoke to two relatives about their experience of the care provided. We spoke with eight members of staff including the operations manager, nominated individual, registered manager and care workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two 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.

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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• One person told us they were "scared" of another person who lived at the home. The registered manager was aware of this but had not implemented appropriate care plans and risk assessments to consider the impact on the person or ways to reduce their anxiety. However, another person told us, staff had "kept them safe" and said the staff had supported them to take the "right steps" to manage their anxieties.
• Care plans and risk assessments were not always updated when people's support needs or identified risks had changed. There was information about people's known risks and how to safely support them, but they did not always reflect changes in need. This meant staff did not always have the most up to date information about people. Staff were able to tell us about how they supported people to stay safe.
• There was no analysis of incident or accidents to identify patterns, trends or themes. Therefore, no consideration had been given to actions that could be taken to reduce further occurrences.
• When staff had sustained injuries at work, they had continued to work with people without medical attention. This meant there had been no consideration if they were safe to remain at work following an injury.
• One person had refused their medicines for five consecutive mornings. The registered manager had not sought medical advice to consider the impact and implications on the person.

A failure to ensure care and treatment is provided in a safe way was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We raised all the concerns identified with the operations manager who was quick to respond and provided us with an action plan. The action plan included updated risk assessments to be implemented and a review of incidents to ensure safety measures were in place. The action plan had allocated time frames for completion and we were provided with updates.

Systems and processes to safeguard people from the risk of abuse
• Allegations of abuse had not been consistently reported to local authority safeguarding teams and investigated. For example, there were concerns for one person who was scared of someone else living in the home and the registered manager had not reported this to local authority safeguarding team.
• There was poor record keeping around management of incidents and use of chemical and physical restraint. A chemical restraint is when medicine is used to restrict the freedom of movement of a person, or in some cases to sedate a person. This had not been identified and explored, therefore placing people at increased risk of abuse.
• Staff had recorded inappropriate language and interventions in incident forms. This had not been

identified and therefore not explored to consider if a safeguarding referral was needed.

A failure to ensure people were safeguarded from risk was 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.

• The operations manager took appropriate action on issues raised. They reviewed all incident forms to ensure any safeguarding incidents were alerted retrospectively and measures were put in place to keep people safe. Staff were able to tell us how they safely managed incidents.

Staffing and recruitment
• We had mixed views from staff about whether there were enough of them on shift. Everyone living at Chance Drive was funded to have staff to work with them all day. We discussed this with the registered manager who confirmed they have safe staffing levels and contingency plans for when they fall below this. They said this would be discussed with the staff team, so everyone was aware of the expectation.
• Pre-employment checks had been carried out including reference checks from previous employers. There were gaps in some staff's education and employment history that had not been discussed before the started work. We raised this with the operations manager and who said a full audit was underway, looking at all staff files to ensure correct information was stored and recorded.

Using medicines safely
• Where people's medicines were in boxes, we found the remaining tablets balanced with what should have been in stock.
• Where people required medicines on an 'as and when required' (PRN) basis, there were protocols in place to guide staff as to when they needed to be administered.
• Staff had competency checks in medicines administration to ensure safe practice. All staff were in the process of having their competency rechecked.

Preventing and controlling infection
• We were assured that the provider was preventing visitors from catching and spreading infections.
• We were assured that the provider was meeting shielding and social distancing rules.
• We were assured that the provider was admitting people safely to the service.
• We were assured that the provider was using PPE effectively and safely.
• We were assured that the provider was accessing testing for people using the service and staff.
• We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
• We were assured that the provider's infection prevention and control policy was up to date.
• Where people had attended A&E, there was no risk assessment to consider how to prevent cross contamination. The registered manager could tell us what measures were in place for people but not staff. We recommended they reviewed and risk assessed people who are likely to need to attend A&E.

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.

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

- Systems and processes did not effectivity assess, monitor and mitigate risk to service users. The registered manager had failed to consistently update care plans and risk assessments. In addition, there was a lack of analysis of incidents to identity patterns and trends. This meant there was a lack of continuous learning and improving care.
- Audits failed to identify where incident forms lacked detail about why or what physical and chemical restraint was used. This meant it was not clear if restraint had been used appropriately and proportionately and the registered manager had not identified and explored this.
- Systems and processes were not established and operating effectively to investigate abuse or improper treatment. Safeguarding incidents had not always been alerted to the relevant authorities or investigated appropriately. We found there had been 23 incidents in a five-month period where a person's anxiety and behaviour that challenged had impacted on the other person. This meant people were at increased risk of abuse.
- Relatives told us they had raised concerns to the registered manager on behalf of people living in the home. These concerns included issues about staff conduct. They told us their concerns had not been acted on and they had not received any feedback. Staff also told us they had raised concern with the registered manager. There were mixed views about whether their concerns were addressed.
- The systems and processes in place had failed to identify where staff had sustained an injury then remained at work without medical intervention or risk assessments. There were 24 incidents recorded over a five-month period where staff had sustained injuries including head injuries. Therefore, the provider could not be assured staff were fit to remain at work.

The lack of robust quality assurance meant people were at risk of receiving poor quality care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The Care Quality Commission had not been notified of events in line with legal requirements.

Not notifying the Care Quality Commission of events that have occurred in the service in line with legal requirements, is a breach of Care Quality Commission (Registration) Regulations 2009: Regulation 18.

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

outcomes for people
• We had mixed feedback about whether staff practice was person centred. Feedback from relatives suggested staff practice was not always person centred but feedback from people was positive.
• The language staff used, when they were recording incidents, was not always respectful and did not promote a positive culture.
• There was no system in place to show how the registered manager kept themselves up to date with day to day culture and staff attitudes, values and behaviours. The registered manger told us they completed spot checks but did not record these. Therefore, there was no clear evidence if good practice or poor practice had been identified and what actions had been taken to address it.
• There had been positive outcomes for one person. They were due to move to a more independent setting to develop life skills. They said they would "miss all of the team" as the staff were "good".

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 registered manger understood duty of candour. However, relatives did not always feel the management team were open and transparent with them. A relative said, "I have to call to get updates. [Person] tells me if there is an incident." Another relative said, "If I was concerned, I don't know who I would speak to. I feel as if we have been left in the dark this past year."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
• The had been no formal feedback requested from people or relatives. This meant there was no opportunity for anyone to formally express their views and opinion in order to aid improvement. The registered manager said they regularly sought feedback but had no documentation to evidence this.
• The registered manager and staff communicated with external health professionals such as psychology and psychiatry. We saw some positive feedback had been sent by external professionals. This evidenced partnership working between the staff team and external professionals.
• Staff understood whistleblowing and told us they knew how to access policies relating to this. A whistleblower is a person who exposes any kind of information or activity that is deemed illegal or unethical.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always safeguarded from risk.

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 18 Registration Regulations 2009 Notifications of other incidents The Care Quality Commission had not been notified of events in line with legal requirements.

The enforcement action we took:

We served a fixed penalty notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of robust quality assurance meaning people were at risk of receiving poor quality care.

The enforcement action we took:

We served a warning notice.