Lifeways Orchard Care Limited

202 Weston Road

Inspection report

202 Weston Road
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
202 Western Road is a residential care home providing personal care to up to 4 people. The service provides support to people who have a learning disability and/or who are autistic. At the time of our inspection there were 4 people using the service.

People's experience of the service and what we found
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. We considered this guidance as there were people using the service who have a learning disability and/or who are autistic.

Right Support
The provider did not always assess risks or take action to mitigate identified risks to ensure people were safe. People were not always safeguarded from abuse or avoidable harm. People were not always supported to receive their medicines in a safe way. The service did not always make sure staff had the skills, knowledge and experience to deliver effective care and support.

The provider was not always working in line with the Mental Capacity Act.
People were not always 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 supported this practice.

Right Care
People were not always protected from the risk of infection as staff were not consistently following safe infection prevention and control practices. People's care and support was not always delivered in line with current standards and people did not always achieve effective outcomes. The provider did not always ensure the service worked effectively to deliver care, support and treatment. People were not always supported to live healthier lives. People were supported to eat and drink enough to maintain a balanced diet.

Right Culture
The provider did not always learn lessons when things had gone wrong. People's individual needs were not always met by the adaption, design and decoration of the premises. The provider did not have an effective management structure. The provider did not always monitor the quality of care provided in order to drive improvements or create a learning culture at the service, so people's care was not improved. The provider did not fully understand or act on their responsibilities under the duty of candour. People and staff were not always involved in the running of the service and their protected characteristics were not always well

understood.

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 11 October 2019).

Why we inspected
The inspection was prompted in part due to concerns received about people's safety, staff training and oversight. A decision was made for us to inspect and examine those risks.

We undertook a focused inspection to review the key questions of safe, effective, and well-led only. For those key question not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

You can read the report from our last comprehensive inspection by selecting the 'All inspection reports and timeline' link for 202 Western Road on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, the premises and equipment, need for consent, person-centred care and good governance.

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

Follow Up
We will request an action plan from 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?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our well-led findings below.

202 Weston 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 Health and Social Care Act 2008.

Inspection team
The inspection team consisted of 2 Inspectors.

Service and service type
202 Western Road 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. 202 Western Road 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
The 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 4 relatives about their experiences of the care people received. We spoke with 5 members of staff including support workers and the area manager. We also spoke with a registered manager employed by the provider, who is providing additional support at the service. We observed staff interactions with people.

We also spoke with professionals from the local authority, who were supporting the service at the time of our inspection.

We reviewed a range of records, this included 2 people's care records and multiple medicines and daily care records. We reviewed 2 staff files in relation to recruitment processes and training. A variety of records relating to the management of the service, including policies and procedures, environmental checks and audits were also reviewed.

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.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse and avoidable harm

- The provider did not always assess risks or take action to mitigate identified risks to ensure people were safe. People were not always safeguarded from abuse or avoidable harm.
- Staff informed us of 1 person's identified health condition, however, there was no risk assessment or guidance available for staff to follow to safely support this person. We requested this be addressed as a matter of urgency, and the provider acted to ensure a risk assessment was in place. However, following our inspection we were notified by the provider of an incident involving this specific healthcare need, and staff did not follow the protocol in place. This placed the person at risk of harm.
- The provider had not always identified risks associated with the environment and premises. This included risk of harm to people where radiator covers were not in place. We requested this be actioned immediately and by our second site visit these were in place.
- We found the provider had identified some risks; however, action was not always taken in response. We reviewed an audit identifying mould in 1 person's bedroom, however, there was no information of the action taken to remove this or reduce the risk to the person. We also reviewed a recent fire evacuation form, with identified improvements, however, there was no detail of how those improvements would be achieved.
- Staff were not always accurately recording accidents and incidents, and these were not inputted on the provider system as per their process. This meant some incidents may not have been reviewed as required to ensure required action was taken.
- Staff did not always effectively support 1 person who displayed behaviours staff found difficult to manage and there was not an up-to-date clear support plan in place to inform staff. This placed the person at risk of harm. One person's relative also confirmed they did not feel people or staff were safe, they told us, "I worry for [Person's name]'s safety, how can they be safe when staff can't manage them."

Using medicines safely

- People were not always supported to receive their medicines in a safe way.
- People's medicine administration records (MAR) contained missing signatures, which meant we could not be assured people had received their medicines as prescribed. We raised this with the area manager to investigate and take any required action.
- Where people were prescribed 'as required' medicines, there were no protocols in place to ensure they were administered in line with prescribing instructions.
- People's medicines were stored in individual locked cabinets, however, temperature checks of these were not effectively completed. We reviewed 1 person's temperature check record which detailed several entries stating the thermometer was broken. No action was taken to report or replace the thermometer. This placed

people at risk of harm should their medicine exceed or fall short of the required temperature.

Learning lessons when things go wrong
● The provider did not always learn lessons when things had gone wrong.
● Staff recorded when incidents took place, however there was no record of the action taken in response to the incidents to help mitigate the risk of the incident happening again.
● We found for 1 person, specific incidents were reoccurring, and whilst the management team had identified this and sourced external support, there was no evidence of the provider analysing trends or recording whether any of the interventions had been successful or not.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. 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.

The provider responded to our requests during and following the inspection and started to make improvements to the service.

● Following our first day of inspection we requested the provider took action to ensure the required protocols were in place, for people's 'as required' medicines, and this was actioned as requested.
● The provider ensured other safety checks of the building and the environment were completed to ensure it remained safe for people, these included completing gas, electrical and fire safety checks.
● Staff we spoke with confirmed the process they followed if they had any concerns including reporting issues to the area manager or covering manager.

Preventing and controlling infection
● People were not always protected from the risk of infection as staff were not consistently following safe infection prevention and control practices.
● The home required areas of refurbishment to help keep it clean. We found rust around the shower cubicle in the bathroom and the side of the bath required replacing. We also found mould had arisen in 1 person's bedroom, which placed people at risk of harm.
● We found areas of the home had strong malodours and cleaning schedules were not regularly completed. We raised this with the area manager who told us they would take action to ensure schedules were regularly completed.
● During our second site visit, we found action had been taken to improve the cleanliness of the home, and people's bedrooms were being redecorated.
● Staff confirmed they had access to personal protective equipment (PPE) and used this as and when required to support people.

Visiting in Care Homes
● People were able to receive visitors without restrictions in line with best practice guidance.

Staffing and recruitment
● We observed enough staff on duty to support and meet people's needs, however, the deployment of staff required reviewing. One member of staff told us, "This weekend worked well because of the staffing group, people all went out, the rota fell that way with decent staff on."
● People's relatives told us not all staff knew people well and the staff were not always consistent. One relative told us, "Some carers are good, but the standards have gone down. It is worrying when you see different staff there all the time, it is a constant change, I think that might be shown in the behaviour

patterns". Another relative confirmed, "We don't know a lot of the staff, there has been a lot of changes."

● People were supported by staff who were safely recruited to work at the home. The provider completed preemployment checks to ensure staff suitability to work at the home.

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Adapting service, design, decoration to meet people's needs

- People's individual needs were not always met by the adaption, design and decoration of the premises.
- The layout and design of the home did not always meet people's individual needs. At the time of the inspection, 1 bathroom was out of use and was being repaired. This meant people only had access to 1 bathroom and 1 other toilet, which staff described as 1 person's individual toilet. People could be restricted as to when they were able to use the bathroom facilities within the home.
- The communal rooms were not designed to meet people's sensory needs and some people's bedrooms were not decorated in line with their preferences.
- Some areas of the home left people at risk of harm, including mould in 1 person's bedroom. Other areas required refurbishment to help keep them clean.

Systems had not been established to ensure facilities were safe, accessible and clean to mitigate risks people using the service. This placed people at risk of harm. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- During and following our inspection site visit, the provider started to address the concerns we found. This included a scheduled review of the premises to ensure all areas were suitable to meet people's needs.
- During the second day of our inspection, we were informed 2 people were having their bedrooms redecorated. One staff member also informed us they were supporting people to choose the paint colour for their walls using sample colours.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (DoLS)

- The provider was not always working in line with the Mental Capacity Act.

● People's DoLS records did not show where applications had been reapplied for following their expiry date, this meant people may have been unlawfully restricted.
● People had mental capacity assessments and best interests in place, however, these were not all decision specific, and some were contradictory. For example, 1 person's records detailed the requirement of support of 2 staff members when in the community, a different document detailed only 1 staff member was required.

Systems were not always effective to ensure people were supported in the least restricted way. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider acted following our inspection to complete required reviews and applications.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's care and support was not always delivered in line with current standards and people did not always achieve effective outcomes.
● We found some people's needs were assessed, and their care records were person-centred and included specific guidance for staff to follow to meet their needs, goals and aspirations. However, these records, had not been regularly reviewed and staff were not always following the information they contained.
● We found 1 person's care record included their goal in relation to using public transport with supportive measures and an action plan and date to achieve this. There was no record of the progress or completion of this goal.
● People's care records detailed their likes, preferences and hobbies. We found, however, there was limited evidence people were supported with meaningful activities or had access to things of interest to them. We observed people sitting for long periods of time in a communal area, whilst staff stood talking among themselves in another area. One relative told us, "[Person's name] used to love travelling, going on coach tours and trains. They would go on holiday every year, they seemed to really enjoy it. It is all gone now."
● We reviewed people's care records which documented ways to promote their independence, however, people were not always supported with this. For example, 1 person's record showed they enjoyed carrying out different household tasks. There was no evidence recorded of this person completing these tasks, and we did not observe this during our site visits.

Staff support: induction, training, skills and experience
● The service did not always make sure staff had the skills, knowledge and experience to deliver effective care and support.
● Staff we spoke with confirmed they did not feel they had the right training and support to meet people's needs, particularly in relation to behaviours that challenge. One member of staff also confirmed the training the provider was sourcing to support staff in this area, was not suitable for 1 person, who displayed these behaviours, due to the approach not meeting their needs.
● Staff approach to supporting people during incidents was not effective. We heard staff shout at 1 person on several occasions when trying to de-escalate situations. Staff were also observed restricting people from communicating in their preferred manner by continually asking them to be quiet.
● External professionals spoken with also confirmed they felt staff did not have the required skills and knowledge to safely support people and meet their needs. One relative also confirmed they felt some staff were not following the routine in place, to safely support their loved one.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The provider did not always ensure the service worked effectively within and across organisations to

deliver effective care, support and treatment. People were not always supported to live healthier lives.
● Staff accessed initial help and support to meet people's needs, however they did not always follow guidance or take further action where required.
● We found 1 person's records detailed where the GP was contacted for guidance and advice due to a potential health condition this person displayed. The GP regarded this health condition as behavioural, however; there was no evidence of any further action taken or contact to other external professionals to support this person with this need.
● People's relatives confirmed staff accessed support when required. One relative told us, "Staff have made referrals recently, [Person's name] has had some behavioural problems and they called lots of different people in to help them."

People were not receiving person-centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded to our requests following the inspection and started to make improvements to the service.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink enough to maintain a balanced diet.
● People's likes and dislikes and food preferences were recorded in their plan of care along with how they liked to eat their meals. For example, 1 person chose to eat their meals outside of the service, which staff supported them with daily as part of their routine.
● People's care records included detail of the recording of food and fluids; however, we did not see any records of these or information around the reason for this monitoring.

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 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

- The provider did not have an effective management structure. The quality of care provided was not monitored in order to drive improvements or create a learning culture at the service, so people's care had not improved.
- The provider had not replaced the previous registered manager or assigned effective management oversight in the interim. The area manager had recently started providing support with a registered manager from another service, who staff confirmed they could go to when required. Despite this, we found there was not a robust management structure to ensure the safe and effective running of the service. One relative also told us, "Since there has not been a regular manager, it has not been good."
- The provider did not have effective systems in place to identify health and safety concerns within the environment for example missing radiator covers.
- The provider had completed regular medicine audits; however, these were not effective. We reviewed a recent audit which identified temperature checks had not been completed due to the thermometer not working. No information was recorded of the action taken to ensure the medicines were stored safely. Errors we found on people's MAR charts, had been identified by the provider but there was no record of any action being taken. It is unclear if the staff responsible received any feedback or additional training.
- People's care records had not been regularly reviewed to ensure they remained up-to-date and reflective of the person's current needs. The provider had not recognised where risk assessments and information were not in place to support with people's identified health conditions or where DoLS applications and MCA records required reviewing.
- We found policies which were out of date and required reviewing and staff were not all trained to meet the individual needs of people living at the home. This put people at risk of not receiving care safely or in line with best practice.

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

- There was not a positive and open culture at the service. and the provider did not have a system to provide person-centred care that achieved good outcomes for people.
- Staff demonstrated a culture where people were not empowered, we observed staff telling people to be quiet when communicating and shouting at them during incidents. One member of staff told us people did not have a good quality of life and this was due to the lack of resources. We observed minimal interactions between people and staff and no support with meaningful activities.

● Staff members used language which also did not always empower people. Staff described people as 'boys' and 'lads' and we observed them telling people to 'be nice, and 'don't be naughty'. We raised this with the area manager, who confirmed they were working to support staff to not use this language.
● People's care records included their input and details around their likes, interests and hobbies. There was limited evidence, however, of the delivery of this to ensure people received person-centred care and achieved good outcomes.

Systems were not always effective at identifying and addressing areas for improvement. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our site visits, the provider informed us of the action they were taking to make improvements and ensure people were safely cared for. The provider had also bought forward the start date of the newly appointed manager.

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 did not fully understand or act on their responsibilities under the duty of candour.
● The area manager confirmed information was shared with people's relatives when incidents occurred in the home. We found however, some staff and the management team did not always recognise when things went wrong. For example, staff approach to incidents and the language they used when supporting people.
● People's relatives confirmed they were not always informed about updates or changes to their relative's needs. One relative confirmed a significant delay in being informed of an increase in incidents their relative was involved in. Another relative told us they were not updated in relation the withdrawing of a medicine their relative was prescribed. This relative did confirm however, they had been informed of their relative's recent health condition.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and staff were not always involved in the running of the service and their protected characteristics were not always well understood.
● People's care records showed their input and preferences into their care, however, these required updating and we were not assured staff were always delivering care in line with them.
● Staff could not always make suggestions to improve the care people received. One staff member informed us they were using the opportunity whilst we were on site to request items for the home, such as cushions and throws for the communal areas.
● Staff attended team meetings, which they confirmed were beneficial. We reviewed the meetings minutes from a recent 'Valuing your team session', which identified the requirement for an activity plan for people living at the home. The meeting minutes also documented having consistent leadership would improve the service.
● The area manager confirmed satisfaction surveys were sent to families of people at the service, however, these were collated at an organisational level to identify themes and trends.

Working in partnership with others
● The provider did not always work in partnership with others.
● Prior to our inspection visit the local authority had completed a quality monitoring visit, they found similar concerns to us, however, these had not been actioned by our inspection. This showed the provider was not effectively working in partnership to improve the service.
● The provider had taken action following the concerns we raised and were in the process of making

required improvements.

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 People were not receiving person-centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Systems were not always effective to ensure people were supported in the least restricted way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Systems had not been established to ensure facilities were safe, accessible and clean to mitigate risks people using the service.

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 17 HSCA RA Regulations 2014 Good governance Systems were not always effective at identifying and addressing areas for improvement.

The enforcement action we took:

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