Jeesal Residential Care Services Limited

Vicarage Road

Inspection report

13 Vicarage Road
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Date of inspection visit:
04 May 2022
11 May 2022

Date of publication:
29 June 2022

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service responsive?	**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
Vicarage Road is a residential care home providing personal/ and nursing care to four people at the time of the inspection. The service is registered to support up to eight people. At the time of the inspection the provider had applied to reduce this number to up to six people. Vicarage Road is a three-storey terraced house with a small courtyard garden. Accommodation is provided over the three floors, with a small communal lounge and kitchen located on the first floor. At the time of the inspection three people were accommodated in self-contained flats which provided a bathroom and lounge area.

People's experience of using this service and what we found
Based on our review of safe, responsive, and well-led the service was not able to demonstrate they were meeting some of the underpinning principles of Right support, right care right culture.

Right Support
The model of care did not maximise people's choice, control and independence. The physical environment did not meet people's needs and placed people at an increased risk of harm. People were not given proper control over how they spent their day as this was compromised due to poor staffing levels and a lack of planning. There was a lack of focus on outcomes for people such as promoting independence.

Right Care
People were not receiving person-centred and safe care. The ability to provide person-centred care was compromised due to low staffing levels, poor care planning and poor engagement with relevant people, such as health and social care professionals. The systems in place to promote person-centred support were not being utilised effectively. There was no meaningful goal planning or activity planning. As a result, people were receiving a poor-quality service. People's rights were not promoted as processes around consent and safeguarding were not effectively implemented

Right culture
Governance systems were ineffective and did not promote a person-centred high-quality culture. Staff morale was impacted negatively by the staffing levels and this in turn impacted on the delivery of the support provided. The provider had not taken timely action to ensure improvements had been made. Engagement with people, their relatives, and other external professionals was not taking place to help identify and ensure improvements were made.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 03 March 2022). The previous inspection was carried out on 26 August 2021. Following this inspection conditions were imposed on the provider's registration at this location. At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about staffing, the environment and the management of the service. A decision was made for us to inspect and examine those risks. The information received raised concerns on how the service was applying the principles of right support, right care, right culture. We assessed the application of these principles during this inspection.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, safeguarding, consent, person-centred care, staffing, and good governance.

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
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 effective findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Vicarage 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.

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 an inspector, a medicines inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Vicarage 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. Vicarage 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.

The service did not have a manager registered with the Care Quality Commission. This means that only the registered provider, and not the manager, 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 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. 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 this information to plan our inspection.

During the inspection
We visited the service on 4 and 11 May 2022. We spoke with three people who used the service and three relatives about their experience of the care provided. The people living in the service were able to communicate with us verbally. We also observed the support provided.

We spoke with five members of staff including the manager, deputy manager, a senior support assistant, a support assistant and an agency staff member. We communicated via emails with the nominated individual. 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 medication records. We looked at three 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.

We spoke with two professionals who have regular contact with the service.

Inadequate

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. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to ensure people were fully protected from risk of harm because risks had not been assessed or mitigated. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider was still in breach of regulation 12.

- Risks in relation to fire and water safety were not thoroughly managed and this placed people at an increased risk of harm. Where actions in relation to these areas had been identified as required, we found timely actions had not been made.
- Risks identified as part of staff recruitment were not sufficiently explored to robustly identify and manage potential risk.
- Care plans in relation to nutrition and bowel management did not identify known risks or provide guidance to staff in how to manage this. Records and discussions with staff did not provide assurance that these risks were being sufficiently managed.
- Staff were not working effectively with health professionals to identify and manage risks. Staff did not take a proactive approach to seek advice and support where risks were identified.
- The support provided to people with distressed behaviours was not effective. This placed people at an increased risk of frequent distressed behaviours. For example, one person had previously had a detailed positive behavioural support plan however this was not being followed and had been replaced by a more basic support plan which contained inaccuracies.
- Two of the three people we spoke with told us they did not like living in the service because of the amount of distressed behaviour and incidents between people.
- The management of incidents was not effective as not all incidents were reported using the provider's system. Where incidents had been reported these did not always evidence timely review.
- No meaningful analysis of incidents was taking place. Incidents did not trigger a review of people's support, care plans or application of lessons learned.

People were not protected from risk of harm because risks were not identified and mitigating actions to manage risk were not always taken. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At our last inspection the provider had failed to ensure infection control procedures adequately protected people and staff from the risk of infection. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider was still in breach of regulation 12.

● No COVID-19 risk assessment for the service had been carried out.
● A COVID-19 contingency plan was in place, but this had not been updated. We discussed the plan with the manager who told us the information in this was not accurate and they would not have been able to implement it should it be required.
● Whilst people had individual COVID-19 risk assessments in place these had not been reviewed or updated considering recent changes. Records showed some people had been accessing the community whilst positive for COVID-19. No risk assessment in relation to this had been put in place.

People were not protected from risk of infection harm because these risks were not effectively assessed. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes
● There were no restrictions on visiting. People were supported to keep in touch with their relatives via regular communication such as telephone calls and visits to see their relatives.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure people were fully protected from the risk of harm or abuse. This was a breach of regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Enough improvement had not been made at this inspection and the provider was still in breach of regulation 13.

● Safeguarding incidents taking place in the service were not always identified by staff and as a result were not reported to external parties as required and to ensure people's safety. We reviewed incident records and found between 1 March and 16 May 11 incidents of verbal abuse and 12 incidents of physical abuse between people living at the service. The provider's record of safeguarding referrals evidenced four referrals during this period.
● We identified two occasions where safeguarding concerns had been raised by two people living in the service. Staff did not respond appropriately to these concerns and failed to carry out robust investigations or consult other safeguarding professionals.

People were not protected from the risk of harm or abuse because safeguarding systems were ineffective and concerns were not always responded to appropriately. This was a continued breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There were not enough staff to meet people's needs. Three of the four people living at the service had commissioned one to one hours. However, rotas provided evidenced only three staff working on shift. The manager told us that with the number of staff working at the service they were unable to provide the commissioned hours.
● Staff told us the number of staff working at the service also impacted the hours they worked, and the support provided to people. One staff member told us, "Staffing levels are pretty bad really. Between us we are doing 12 to 14 hour shifts, we are also doing these either side of sleep in [shift], it's not fair on the service users because we get tired."
● All staff spoken with told us staffing levels were not sufficient and did not take into account additional duties that existed outside the one to one support required. One staff member said, "[Staff] just can't do the one to one with everything else you have to complete on the daily shift. With the paperwork, the cooking, cleaning, daily checks and sheets, the updates on the support plan. We need more than three staff but not really got enough staff to provide this."
● Shifts were not clearly organised, there was no designated staff to provide the allocated one to one hours. Staff told us they worked between themselves to sort this out. During the inspection we observed people who should be receiving one to one support not receiving this.

There were not enough staff to meet people's needs and arrangements for the deployment of staff were ineffective. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Staff were trained and assessed for their competency to handle and give people their medicines safely.
● Records showed overall that people received their medicines as prescribed. There was a system in place to report incidents and investigate errors relating to medicines.
● Medicines were stored securely, however, appropriate arrangements were not in place for the storage of controlled drugs (medicines requiring additional security).
● There was written guidance to help staff give people their medicines consistently and appropriately, however, not all medication care plans had recently been reviewed.
● Written guidance for medicines prescribed on a when required basis (PRN) was available for medicines prescribed in this way. However, some of the guidance lacked clarity and sufficient person-centred detail to enable people's medicines to be given consistently and appropriately by staff.
● We found that for one person, arrangements had not been made for them to receive regular medication reviews by prescribers in line with national guidance.

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 requires improvement. At this inspection the rating has deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure staff were adequately trained and supported to meet people's assessed needs. This was a breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Enough improvement had not been made at this inspection and the provider was still in breach of regulation 18.

- Whilst some improvements had been made regarding training levels in the service, we identified some areas of training that still required further work. For example, not all staff had up to date training in emergency first aid. Rotas showed on some night shifts none of the staff on shift had up to date training in this area.
- The provider's policy of mandatory training for staff specified training in mental health and learning disability however this or equivalent training was not included in the list of training staff had received. Some of the people living in the service had diagnosed mental health conditions as well as a learning disability.
- The provider's policy stated staff should receive training in professional boundaries however only the manager had completed this training.

People were not supported by staff who were adequately trained and supported to meet people's assessed needs. This was a continued breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

At our last inspection the provider had failed to ensure the service was acting in accordance with the MCA and the code of practice. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider was still in breach of regulation 11.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Staff had failed to identify that restrictions imposed on one person due to changes to their support prompted by COVID-19 required an authorisation.
- Whilst some MCA assessments had been carried out this was not the case in all relevant areas. For example, in relation to accessing the community or nutritional support.
- One person had a DoLS in place and authorised with specific conditions. The manager was not aware of these conditions and these were not being met.

People's rights were not protected because the provider had failed to ensure the service was acting in accordance with the MCA and the code of practice. This was a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to eat and drink enough to maintain a balanced diet; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Staff were not always proactive in seeking input from health professionals. The manager was not clear on what specialist learning disability services were available and how to access these.
- Where input had been received from health professionals this had not always been incorporated into the support provided. Staff were not always clear on health professionals' recommendations and how the support should be implemented. We found this information was not always shared with members of the staff team
- Two people had come to live at the service less than a year earlier. Staff told us that people's individual needs and personalities had not been thoroughly considered and assessed. People, staff, and professionals told us the people living in the service did not have good relationships with each other.
- Care plans for people's nutritional support were not detailed and did not identify the support required in this area. It was not always clear that people's nutritional needs were being met.
- Healthy eating plans were not always in place, those that were in place did not provide detailed guidance. Weight records did not evidence effective support in this area.
- Menus were discussed and planned with people at weekly meetings. One person told us they did not like the meals provided as staff did not cook them in line with their preferences.
- People's needs were considered holistically. However, assessments and care plans were not always up to date and did not adequately reflect people's needs and choices.
- Best practice and guidance was not always implemented effectively in relation to supporting people when distressed, with healthy eating, and bowel management.

Collaborative assessments of people's needs, and preferences had not been carried out. This was a breach

of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

●The physical environment did not meet people's needs. Communal areas on the first floor were no longer in use. Whilst three of the four people living in the service had a lounge within their own living space, we observed people choose to spend time outside of their own living space in the communal areas. However, we noted, and staff confirmed, that people living in the service did not always have positive relationships with each other. This meant when people were accessing communal spaces at the same time, they were in close proximity to each other.

● Staff told us the changes to the physical environment and the increased proximity of people to each other had contributed to the number of safeguarding incidents occurring between people. One staff member told us, "I think the structure of our house isn't suitable for three one to one tenants who have got behaviours." A health and social care professional told us the environment was "not suitable at all."

Inadequate

Is the service responsive?

Our findings

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

At the last inspection of this key question in 2019 this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them; Meeting people's communication needs; Improving care quality in response to complaints or concerns

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

- The support provided did not always meet people's needs. Where people's needs had changed care plans had not been put in place to ensure the person and staff understood the support needed.
- People's communication needs had not been fully considered and supported. A health professional for one person had provided detailed guidance for staff on how to support communication with the person. However, this had not been incorporated into the support provided and staff were unaware of this guidance.

- The manager told us no formal complaints had been made since the last inspection. We asked the manager what accessible information was provided to people regarding how to make a complaint, for example in an easy read format. The manager told us this information was not available.
- Following our inspection the provider supplied us with an easy read leaflet for people about how to make a complaint. However this remained a concern because the manager was not aware of this leaflet and it was not accessible to people living in the service.
- We identified health needs for people that had not been sufficiently identified, explored, and planned for. It was not clear that staff had taken action to address these needs in sufficient depth.
- There was no clear activity planning and people's needs in this area were not well met. One person told us they got bored and two relatives told us people were not supported to do enough and this had a negative impact on their well-being. A relative said, "The lack of activity, I think it's effecting [family member's] wellbeing. It does appear there is a limited number of staff to do activities. Not sure how many one to one hours [family member] gets. [Family member] does the same thing every day. Out for a coffee, then hanging around the house."
- Systems that were in place to help review and ensure people's needs and wishes were met were not being implemented in a meaningful way. For example, people had care plans in place regarding their goals and future plans however these were not meaningful and linked to positive outcomes for the person. We also found these were not regularly reviewed to see if the goal had been achieved.

People's needs were not met. The care provided had not been designed with a view to achieving people's preferences and needs were met. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

End of life care and support

- No one was receiving end of life care and support at the time of the inspection.

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 inadequate. At this inspection this key question has remained the same. 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 our last inspection the provider had failed to ensure adequate systems were in place to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider was still in breach of regulation 17.

- At this inspection we found improvements had not been made and the provider remained non-compliant with all breaches of the regulations identified at the previous inspection. This meant we had little assurance that effective governance systems were in place and improvements would be met.
- Following our previous inspection in August 2021 conditions were placed on the provider's registration at this location. At this inspection we found the conditions were not being fully met.
- Following our inspection the provider shared with us an action plan written following the previous inspection in 2021. This did not show the action plan had been kept under regular review and we noted out of 13 identified required actions only one action had been marked as completed. This was not timely and effective action to ensure improvements were made.
- Feedback from people and their relatives to evaluate the quality of support had not been sought. This was despite this concern being raised at the previous inspection.
- Where issues had been identified we found timely action had not taken place and no learning was identified and applied.
- Systems to manage identified risks, such as incidents, had either not been established or were ineffective.
- Records relating to people's care were not accurate. This is a regulatory requirement.

Governance systems were not effective and had not supported improvements to the quality and safety of the care provided. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The systems in place were not effectively used to ensure the delivery of person-centred care. This was further compounded due to low staffing levels. This meant a person-centred culture was not promoted.
● Staffing levels were such that staff were working long hours and staff reported this impacted on morale. Staff also reported that they did not always feel valued by the provider.
● Relatives told us communication with them was not open and inclusive. One relative told us, "Not good recently. The home had a Covid outbreak. I was not informed by the home that [family member] had Covid and found out from the Social Services Team when I was trying to arrange a visit." A health and social care professional also told us they felt staff were not always open and informative with relatives.

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
● Due to concerns identified with the reporting of incidents in the service and communication with relatives we could not be fully confident the requirements of duty of candour could be met.

Working in partnership with others
● Staff were not working effectively with other professionals to support and develop the quality of care provided to people.
● The provider was being supported by the local authority and other external parties. Despite this the quality of the service had deteriorated. This raised concerns about how the provider was meaningful engaging with the support provided.