Accomplish Group Limited

Wings

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

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.

About the service
Wings is a residential care home providing personal care to up to six people. The service provides support to adults with a learning disability, autistic people, mental health, physical disability and older people. At the time of our inspection there were six people using the service. Wings is a bungalow, all rooms are single, bathrooms are shared. There is a medium sized garden that is enclosed by a six-foot wooden fence. There is an office and a sleep-in room located in a separate building.

People's experience of using this service and what we found
The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support: Wings is rural in location and to access the community would require access to transport. People were not consistently able to access planned day time pursuits because of a lack of staff who knew people well and could drive. This led to disappointment and sometimes anger for people.

Externally the care home fitted into the surroundings. However, the six-foot fence was not in keeping. Internally the environment had been improved since our last inspection with a newly fitted kitchen and décor throughout. The kitchen was accessible to everyone.

Right Care: People were not always encouraged or supported to become as independent as they could be or have choice and control over their support. One person had their liberty restricted by a locked gate and this led to others being restricted too. People did not receive planned and coordinated person-centred support that was appropriate and inclusive for them. An example being how medicines were managed. Everyone had medicines dispensed to them from one locked cabinet and people were asked to attend and wait their turn.

Right Culture: The values of the newly appointed registered manager are based upon empowerment and inclusivity. Therefore they will challenge the attitudes and behaviours of some of the embedded practices relating to choice and control to enable people to have their best lives whilst being appropriately supported.

People were not consistently supported to have maximum choice and control of their lives and staffing levels impacted upon the least restrictive way possible and peoples best interests; the systems in the service did not consistently support this practice.

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 1 April 2020) The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support right care right culture.

This inspection was prompted by a review of the information we held about this service. 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.

We have found evidence that the provider needs to make improvements. Please see 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. For those key questions 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 reports' link for Wings on our website at www.cqc.org.uk.

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 have identified breaches in relation to staffing levels, person centred care and the service being well led by the provider 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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 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 responsive?

Requires Improvement

The service was not always responsive.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Wings

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
One inspector completed this inspection.

Service and service type
Wings 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. Wings 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
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. Inspection activity started on 5 April 2022 and ended on 13 April 2022. We visited the service on 5 April 2022.

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 three people who used the service about their experience of the care provided. We spoke with four members of staff including the registered manager.

We reviewed a range of records. This included three 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.

After the inspection
We continued to seek clarification from the provider and spoke to six staff via email to validate evidence found. We looked at training data and quality assurance records. We spoke with one professional who knew the service.

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 our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained 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.

Staffing and recruitment
At our last inspection the provider had failed to have sufficient staff available. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18

- There continued to be insufficient staff available to meet people's needs in a timely way. The high usage of agency was maintaining the service at a safe level, but there was impact upon people and permanent staff.
- The roster showed us that the permanent staff were altering their shift patterns and picking up some additional shifts. One staff member said, "It's had a massive impact on both the staff and residents as it seems as if the staff are being pressurised to pick up extra shifts and the residents are constantly having different agency staff." On occasion staff said that agency staff did not turn up for night shifts and this had led to staff not able to leave the shift. Some staff said that two staff on shift in the late shift (evenings) was unsafe.
- People told us that they were not consistently able to access their planned activities. One staff member said that people had, "Appointments and to their place of work etc but they sometime can't go due to lack of staff which leads to them getting angry and frustrated."
- It was not apparent from rosters or daily notes how funded one to one hours were allocated. People had been assessed as needing one to one support. This had been funded, but we could not evidence that this was in place to meet people's needs.

These concerns were all identified at the previous inspection on 22 January 2020. This is a continued breach in regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We could not improve the rating for safe from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

- Robust recruitment procedures were followed to ensure the right people were employed to work in the service. This included Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. References and employment history were explored and evaluated. Health screening of staff ensured they were physically and mentally suitable for the role.

Using medicines safely

● Processes were in place for the timely ordering, supply and storage of medicines.

● Medicines administration records (MARs) were in place for all people at the home to support staff with the administration of medicines. There were no gaps in the records.

● Medicines were administered in a timely manner but not always in a way that respected people's preferences. For example, we saw two people reminded it was medicine time and they came to the dining room (outside the office) and waited for their medicines to be dispensed.

● People were not supported to self-administer their own medicines with safeguards built into that process.

● Protocols to help staff know when to give 'as required' medicines were in place. One relative told us they were very pleased that their relative was supported to take their medicines regularly and how this had enabled them to enjoy a better quality of life.

● The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

● Staff had undergone medicines training and their competency was checked regularly.

Assessing risk, safety monitoring and management

● Some risks to people's safety and welfare were assessed. The new registered manager was developing the risk assessment process. The changes related to ensuring people had choice, self-determination and the least restrictive approach allowing for positive risk management. Thus, enabling people to make decisions for themselves. But also, to weigh up people's abilities, histories and mitigate where possible to keep people safe. Examples included using equipment to remain independent within Wings and accessing the community independently.

● People using the service were involved in the care planning process. All staff said they were aware of the risk assessments in place and that these were kept under regular review. We saw evidence through care plans and team meeting minutes that reviewing risks was ongoing.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met. Actions were being taken to ensure DoLS authorisations that had expired were completed in a timely manner.

● The newly appointed registered manager was reviewing practices within Wings to ensure they were as least restrictive as possible. All staff should know the legal status of people residing at the service and any restrictions placed upon them because of that legislation. We found not all staff were clear of restrictions placed on people.

Systems and processes to safeguard people from the risk of abuse

● People were protected from the risk of abuse.

● People told us they felt safe. A relative said that they trusted the staff and that they, "Were watching out for

[named relative]".
● Staff had received safeguarding training and knew how to recognise and report any concerns about people's safety and welfare. One staff member told us, "I understand safeguarding and whistle blowing. I have reported an issue in the past and it was dealt with accordingly."

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 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.

Visiting in care homes
● People were able to receive visitors and were able to go out and see their families. Government guidance of the time was followed. A relative assured us that they felt their relative had been safe during COVID-19 and that they visited regularly and felt safe with the measures in place.

Learning lessons when things go wrong
● The registered manager was open to feedback and used reflective practice to develop the service for people. An example of this was the monitoring of accidents and incidents. Through this a pattern of events had been noticed and action had been taken to review and re assess the equipment a person used to make them safer but maintain their independence.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained requires improvement. This meant people's needs were not always met.

At our last inspection the provider had failed to ensure peoples care and support was designed and delivered to meet their needs and preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

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

- Inclusive, empowering person-centred care had not been developing in line with principles of Right support, right care, right culture.
- People were not always enabled to make choices and take part in activities which they enjoyed, including accessing their community. One person told us of their distress at being unable to go out of an evening and attend social events due to staffing arrangements at the service. The staff told us of the weekly occurrence that people missed their daily planned activities. On the day of our visit people had missed their daytime occupations because there were insufficient staff that could drive or had other skills to support them.
- People's records were not individualised and centred on that person. Whilst the provider had set templates for assessing and care planning, those were not chosen and developed around the specific needs of the individual. One person's needs were linked to mental ill health and a specific health condition. These were the key factors that required assessing and planning with clear aspirations known. All people had a falls risk assessment completed even though this was not required for them as an individual.
- One person had no family or representative. They had limited communication therefore they needed support of an independent voice. The provider had not sourced this to develop a person-centred plan that involved them.

People's needs had not been fully assessed to ensure their care and support was designed and delivered to meet their needs and preferences. This was a ongoing breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Meeting people's communication needs
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.

- People's records detailed support they required to enable them to maximise effective communication.
- Care plans included information on effective communication with people. For example, one person's care

plan detailed how they had no speech but used non-verbal communication methods. These included head movements, body language and hand gestures to help make themselves understood to others. On the day of our visit staff were able to understand the person was in pain and sought medical intervention for the person.

● Information such as the fire alarm procedure were available in easy read formats to help people understand them.

Improving care quality in response to complaints or concerns

● The provider had a complaints policy that included information about how to make a complaint and what people could expect to happen if they raised a concern.

● No formal complaints had been received.

● There was an easy read complaint procedure for people which was displayed in the hallway.

End of life care and support

● At the time of our inspection visit there was nobody receiving end of life care.

● Records showed that people were offered the opportunity to discuss their final wishes. This could be developed further to ensure plans are in place for everyone and show they reflect the persons cultural and individual identity as well as the functional processes to be followed.

Requires Improvement

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 requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider had failed in managerial oversight. This had impacted the service and people living there. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made on good governance and at this inspection and the provider was still in breach of regulation 17

- The provider has not understood their obligations relating to ensuring quality performance. Wings is remote from the other services of this provider. Quality interventions at Wings since October 2021 is positive. The date of our last inspection visit was 22 January 2020. Therefore, whilst this demonstrates recent oversight and actions put in place, we have not found timely actions that have been embedded and sustained over the two years between our inspections.
- The provider's values of enabling people to work towards their goals, live more independently and take control of their lives as well as supporting people to achieve their full potential were not demonstrated through their practice or within their systems and processes at Wings. There was a lack of oversight by the provider to ensure that people received good quality, person-centred care.
- Inclusive, empowering person-centred care had not been developing in line with principles of Right support, right care, right culture. The newly appointed registered manager had the correct values, but the culture and practices within Wings were not up to speed. The restrictions placed upon one person with regards access and freedom of movement outside of the enclosed garden was placed upon everyone that resided at Wings. One person had a rewards system reviewed and stopped. Another care plan spoke of handing in devices to access the internet. This practice was not followed by staff now.
- People were not empowered to manage their own medicines. People were summoned to an area within the building by staff when it was time to receive their medicines. They remained outside the room until staff emerged with their medicine.
- The lack of skilled permanent staff that knew people well and that were trusted by people living at Wings was an ongoing issue. We were informed that there were the equivalent of four and a half whole time staff posts still vacant. Some 175 hours per week were vacant. The provider had allowed the use of agency. Staff

from other locations had travelled from places such as St Neots to work shifts. Pay at the service has been reviewed multiple times to address the staffing difficulties experienced.

● The complex and diverse needs of people living at Wings was not readily able to be filled by the skill set of temporary staff. Therefore, permanent staff were required to be on duty and lead shifts. We observed one person living at the home reminding and showing a temporary staff member how to turn off the cooker. This was of concern as the staff member was present to ensure kitchen safety whilst baking. Permanent staff spoke of being tired due to overseeing agency and picking up additional hours above their contracted hours.

● The impact upon people was that they were unable to consistently access activities outside of the service as was determined to meet their needs as part of their assessment and funding from the placing authorities. One factor being that agency staff were unable to drive the vehicles at Wings that was not near public transport.

The shortfalls in managerial oversight and leadership impacted the service and people living there. This was a ongoing breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The current manager started at Wings on 1 November 2021 and was registered in March 2022. Therefore, has been unable to effect all the changes required at Wings. The registered manager has plans for developing the service and understands about achieving good outcomes for people. Wings was assigned to Accomplishes Assurance Improvement Monitoring process which recognises and provides additional support and this is a positive step.

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; Continuous learning and improving care

● The registered manager understood the types of incidents that need to be reported to CQC and had notified us of relevant events. These were used as reflective practice within team meetings to improve care for people. Staff had access to ongoing updates and training. This was monitored by the registered manager to ensure staff attended training refresher courses.

● The registered manager was open and transparent when dealing with any issues or concerns. They understood their responsibility to apologise and give people and explanation if things went wrong.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The registered manager made themselves easily accessible to people using the service, their relatives and staff. This gave them the opportunity to share any concerns or feedback about the service. There was a weekly meeting with the people at Wings and minutes kept. One relative told us that they were kept informed and up to date and had nothing but praise for the service.

● The service worked with other health and social care professionals to ensure people received consistent and timely care. Records noted the involvement of family members, social workers, GPs and district nurses.

● The registered manager and staff understood the importance and benefits of working alongside other professionals.

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's needs had not been fully assessed to ensure their care and support was designed and delivered to meet their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were shortfalls in managerial oversight and leadership impacted the service and people living there

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to have sufficient staff available to meet peoples needs.