Jeesal Residential Care Services Limited

# Ashwood House - Norwich

## Inspection report

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Date of inspection visit:
02 July 2020

Date of publication:
05 January 2021

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

About the service
Ashwood House-Norwich is a residential care home providing personal care to up seven people with learning disabilities, autism and mental health conditions. At the time of the inspection seven people were living in the service. The service accommodates five people in the main house with a shared communal lounge and kitchen. Accommodation for a further two people is provided in two self-contained flats. The service had been registered prior to Registering the Right support, however it met key characteristics due to its small size, position in the local community, and homely environment.

People's experience of using this service and what we found
The service didn't always consistently apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence. The outcomes for people did not fully reflect the principles and values of Registering the Right Support because restrictive practices were not fully assessed and kept under review.

Systems were not in place to ensure restrictive practices were fully assessed and kept under review. Systems around the management and review of restraint were not operating effectively. Whilst most safeguarding concerns were reported we found incidents where some were not. This compromised the oversight and ability of external agencies to monitor and respond to potential safeguarding concerns.

Risks to people were not always identified and assessed. Actions to mitigate risk had not always been taken. The provider had not acted to assure themselves that staff had the skills and competency to support people with moving and handling tasks. No thorough analysis of incidents was occurring overall in the service which took account of patterns and trends to prevent reoccurrence.

A robust framework for quality monitoring and improvement was not in place. There was lack of provider oversight of the service and this also impacted on the ability of the service to make improvements. We found some instances where people's written information was not accurate or omitted.

Some incidents that had taken place in the service raised some concerns about their being a closed culture. By a closed culture we mean a poor culture that can lead to harm, which can include human rights breaches such as abuse. However, people, relatives, and staff spoke positively about the service and of the support provided. Staff ensured there was regular contact and involvement with relatives. There were systems in place to ensure people's views and opinions were listened to. The management team were open and receptive to feedback. Where we identified issues at this inspection the management team took responsive action to address concerns which included working collaboratively with other agencies.

Medicines were managed safely, and people received these as prescribed. We identified areas of good practice in relation to infection control and management, this included the service's response to Covid-19.

Following incidents that occurred in the service, these were reviewed and discussed with staff as part of a learning response.

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 23 April 2019)

Why we inspected
The inspection was prompted in part by concerns relating to a notification of an incident which could have resulted in serious harm to staff and people using the service. The information CQC received about the incident indicated concerns about the management of distressed behaviours for people who use the service. Subsequent conversations with the service also identified concerns about the management of risk in relation to Covid-19. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this report.

You can see what action we have asked the provider to take at the end of this full report.

Following our inspection, the provider took immediate action to address some of the issues identified. This is detailed within the safe and well led sections of this report.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ashwood House-Norwich on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the Covid-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified breaches in relation to safeguarding services users from risk of abuse, safe care and treatment, 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
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

**Is the service well-led?**

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

# Ashwood House - Norwich

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by three inspectors.

Service and service type
Ashwood House- Norwich is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave a short notice period of the inspection because we needed to discuss, assess, and plan our visit to the service due to the Covid-19 pandemic.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from professionals who work with the service and the local authority. We reviewed the information the provider sent us in the provider information return submitted in February 2020. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

Due to the Covid-19 pandemic the first day of inspection was carried out by two inspectors visiting the service for a shorter period of time. The rest of the inspection was carried out remotely by the lead inspector and second inspector who made calls to staff and relatives away from the site. The lead inspector also reviewed documents relating to the care provided and management of the service away from the site. This inspection activity took place between the 2 July 2020 and 30 July 2020.

During the inspection we spoke with two people who used the service and three relatives. We spoke with eight staff, this included the registered manager, two deputy managers, a team leader, a senior support worker, two support workers and a night staff member. We received written feedback from another two night staff. We contacted a further five staff members to seek their feedback, but they did not respond to our contact.

Following our site visit we also had email contact with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed the care plans for four people using the service, the daily notes for two of these people and records relating to the management of risks in relation to nutrition for a third person. We reviewed three people's medicine administration records. We reviewed records relating to incidents in the service, staff training, meeting minutes, and two staff recruitment files. A variety of records relating to the management of the service were reviewed, this included audits and policies.

After the inspection
We had further contact with the registered manager to assess and validate evidence found. We also spoke with one health care professional for their feedback on 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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- Systems were not in place to ensure restrictive practices were fully assessed and kept under review. For example, staff used a listening device to listen to one person in their room at night. Whilst an initial mental capacity assessment for consent to use the device had been carried out, this was completed in 2014. There had been no further assessments or reviews of the device. We found a support plan regarding its use was also not in place. This meant we were not confident that the measures in place were not overly intrusive and had considered people's human rights.
- It was not clear within the service's own systems that restraint was being recognised sufficiently. For example, on several occasions staff had used physical restraint but the incident report completed after these occasions did not identify the use of restraint and questions on its use were not completed. This also meant that systems around the management and review of restraint at provider level were not able to operate effectively in ensuring the use of restraint was proportionate and necessary.
- Staff were not following the provider's own policy regarding the use of restraint in respect to care planning and review, which meant we could not be confident that systems and processes were being utilised to safeguard people from the risk of abuse.
- Most safeguarding incidents had been reported appropriately and action taken, however we found incidents of unexplained bruising and injuries which had not been reported to the local adult safeguarding team. This compromised the oversight and ability of external agencies to monitor and respond to potential safeguarding concerns.

Systems and processes were not operated effectively to prevent and investigate potential abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks to people were not always identified and assessed. For example, risks relating to moving and handling, fire, and interaction with other's outside of the service had not always been assessed.
- Where risks had been identified the guidance for staff on managing these risks was not robust. For example, there was a lack of information for staff on how identified nutritional risks could be managed or episodes of distressed behaviour.
- Staff were not adequately responding to identified risks. For example, incident reports demonstrated staff were not always following one person's positive behaviour support plans and we identified further actions required to assist another person around their nutrition.
- Whilst most environmental risks had been responded to, we found wardrobes were unsecured, and in one

case, posed a high risk of injury. Risk assessments in place had not been effective at identifying this risk. The registered manager immediately took action to address this risk following our inspection.
● Whilst some staff, but not all, had received practical moving and handling training, for a number of staff this was several years ago. One person had experienced changing levels of needs with their mobility and additional equipment had been supplied to support their mobility. No additional action had been taken by the provider to assure themselves that staff were still competent and that the training staff had received was still sufficient to meet this changing level of need. This placed people and staff at risk of harm.

Risks to people were not always assessed and actions not always taken to mitigate against risk. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● A system was in place to report and review incidents that occurred. We found there was no thorough analysis of incidents occurring overall in the service which took account of patterns and trends and to prevent reoccurrence. The provider had a system which provided a function for oversight and analysis, but it was not clear how this was being used and how it informed actions being taken.
● Incidents were discussed with staff which helped to inform learning and did provide some level of analysis in to the incidents that occurred.

Staffing and recruitment
● There were not always enough staff on to support people at night. Some people's support plans showed they may require support at night and each person's fire evacuation plan showed they would require assistance to evacuate however there was only one staff member working at night time. One person on shift would be unable to safely meet everyone's needs.
● Some staff told us on occasion the service had been short staffed, but this did not impact significantly on people using the service. One staff member said, "I think general support it impacts, you are on your 1-1 but you are helping the main house out as well". The registered manager told us they had measures in place to ensure shifts were not left short staffed by using staff at a nearby service or a member of the management team.
● Following our inspection visit the provider and registered manager took prompt action to increase staffing numbers at night.
● Appropriate recruitment practices were in place to ensure the suitability of staff recruited.

Using medicines safely
● People's medicine administration records showed medicines had been administered as prescribed.
● Information and guidance on 'as required' medicines for people was provided.
● Regular audits to ensure medicines were given correctly were carried out.

Preventing and controlling infection
● Staff were wearing the correct personal protective equipment in accordance with Covid-19 government guidance. Appropriate Covid-19 risk assessments had been carried out, this included individual Covid-19 risk assessments for each person and staff member.
● The environment was clean and tidy. Cleaning schedules were in place. These had not been extended to cover more frequent cleaning of high-risk surface areas due to Covid-19. However, the registered manager confirmed staff were aware and cleaning high risk areas. We saw there was written guidance in place for staff to ensure they cleaned and minimised the risk of infection when using an external building for activities.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement: This meant the systems, culture, and management did not always support the delivery of high-quality, person-centred care.

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

- A robust framework for quality monitoring and improvement was not in place. Whilst some audits were carried out these were not extensive. The lack of a quality monitoring framework meant that areas of concern, such as those detailed under safe, had not been identified. Consequently, this had impacted on the service's ability to meet regulatory requirements and make improvements.
- There was lack of provider oversight of the service and this also impacted on the ability of the service to make improvements. The only provider audits carried out were an annual health and safety audit and a financial audit in 2019. No other provider audits on the quality and safety of the service had been carried out. Whilst some provider oversight was in place via some systems, such as incident reporting systems, these were not being effectively utilised.
- Written information within people's care plans was comprehensive but we found examples where information and risks were omitted or not considered as detailed in the safe section of this report. There were no audits in place to ensure the quality of care plans was sufficient.

Systems and processes were not effective in ensuring compliance. This included in relation to the management of risks, safeguarding, and staffing. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manger told us the provider had recently contracted an external professional to undertake an audit and inspection of the service. This was due to take place prior to the Covid-19 pandemic but had had to be put on hold.

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

- Some incidents and findings at this inspection raised some concerns regarding a closed culture in the service. By a closed culture we mean a poor culture that can lead to harm, which can include human rights breaches such as abuse. We discussed these concerns with the registered manager. We saw that where such incidents had taken place, the management team had taken action to address this with individual staff and set out their expectations for the wider staff team regarding staff behaviour and approaches. However, with some incidents we felt the response could have been more robust and comprehensive. For example, poor behaviour was discussed but no additional training was considered.

● Incidents and the use of restraint in the service had not been identified and dealt with in line with the provider's own policies. This compromised people's human rights. Poor monitoring and review of restraint contributes to a closed culture developing.
● People, relatives, and staff talked positively about the service and support provided. They spoke about a person centred and supportive management team. One relative said, "They do say whatever [name] wants they will get." A staff member said, "Know the management team for years I am comfortable approaching them. It hasn't changed since I've been there."
● Staff ensured there was regular contact and involvement with relatives. One relative told us how staff had gone out of their way to ensure they were involved and consulted in their relative's care. Another relative told us how staff had purchased an electronic device for their relative so they could keep in touch, particularly during the Covid-19 pandemic.
● There were systems in place to ensure people's views and opinions were listened to. This included regular reviews of people's support with them and as well as regular resident meetings.

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
● Incident reports did not evidence who had been informed following an incident occurring. However, relatives told us they found staff open and honest. One relative told us that staff told them, for example, whenever as required medicines were used. Another relative said, "I can trust the staff. I get to know what's going on." A third told us, "Staff immediately get in touch if anything has happened."

Continuous learning and improving care; Working in partnership with others
● The management team were open and receptive to feedback. They were committed to achieving good quality care. Where we identified issues at this inspection the management team took responsive and quick action to address concerns.
● The registered manager took action to ensure they were up-to-date with social care guidance. They were aware of recent changes and requirements within both wider and local social care.
● The management team had good relationships with local commissioners and other professionals which they utilised to help make improvements and meet people's needs.

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 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>How the regulation was not being met: Risks to people were not always assessed and actions not always taken to mitigate against risk. This placed people at risk of harm.<br><br>Regulation 12 (1) (2) (a) (b). |

**The enforcement action we took:**

We imposed conditions on the provider's registration at this location.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>How the regulation was not being met: Systems and processes were not operated effectively to prevent and investigate potential abuse.<br><br>Regulation 13 (1) (2) (3). |

**The enforcement action we took:**

We imposed conditions on the provider's registration at this location.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>How the regulation was not being met: Systems and processes were not effective in ensuring compliance. This included in relation to the management of risks, safeguarding, and staffing.<br><br>Regulation 17(1) (2) (a) (b) |

**The enforcement action we took:**

We imposed conditions on the provider's registration at this location.