Options Autism (6) Limited

Options Malvern View

Inspection report

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Date of inspection visit:
09 February 2022
10 February 2022
14 February 2022

Date of publication:
08 July 2022

Ratings

Overall rating for this service	Inadequate

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

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 autistic people and providers must have regard to it.

About the service
Options Malvern View is a residential care home that provides personal care and support for up to 33 people with a learning disability and autism. At the time of the inspection there were 29 people living at the service. The service is on a large site which is separated into five distinct living areas called Stour, Brook, Everest, Severn and Avon.

People's experience of using this service and what we found
The provider could not demonstrate how the service met the principles of right support, right care, right culture. This meant we could not be assured of the choices and involvement of people who used the service in their care and support.

Right Support
The service did not support people to have the maximum possible choice, independence or have control over their own lives.

Staff did not always do everything they could to avoid restraining people. The service did not always record when people were restrained, which meant that a review of the incident was not undertaken to assess how the need for restraint could be avoided or reduced. Staff were unable to learn from the review to improve their practice and people, were at risk of injury from inappropriate use of restraint or restrictive practices.

People did not always have the support they needed to meet their needs and keep them safe. This increased the risks to people's health and wellbeing.

Right Care
The service did not have enough appropriately skilled staff to meet people's needs and keep them safe.

Staff were carrying out restrictive actions with people without relevant training on how to do this safely or in line with the person's own care plans and risk assessments. This placed people at risk of neglect or injury because care was not always provided by suitably qualified, skilled and experienced staff.

People's care, treatment and support plans did not always reflect their range of needs or promote their wellbeing and enjoyment of life.

People who had behaviours that may challenge themselves or others, had proactive behaviour strategies in their care records. However, this did not provide detail on the specific actions staff should take to ensure practices were least restrictive to the person and reflective of a person's best interests.

Right culture
Care was not always person centred and people were not empowered to influence the care and support they received. One person told us, "I am talked through and not to."

The systems for reporting were not always open and transparent. For example, commissioners of care were not always notified how people's care and support was managed therefore had no oversight.

The governance systems the provider had in place were not always effective. Governance systems did not ensure people were kept safe and received a high quality of care and support in line with their personal needs.

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 14 October 2021) and there were breaches of regulation. 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.

We received concerns in relation to staffing, management and care for people that lived there. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

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

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

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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, staffing, safeguarding and governance at this inspection.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Options Malvern View on our website at www.cqc.org.uk.

Follow up
we wrote to the provider and requested some information to be sent to us urgently, outlining what they were going to do to mitigate the risks identified and to keep people safe. The provider responded demonstrating some immediate actions taken.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
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 well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Options Malvern View

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
Three inspectors carried out this inspection.

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

Notice of inspection
This inspection was unannounced.

What we did before 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 one person who used the service and observed how other people were being supported. We spoke with six members of staff including senior operational staff, the registered manager and team leaders. We also spoke with one health professional and one social care professional. We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at two agency staff profiles and four staff files in relation to safe recruitment and a variety of records relating to the management of the service, including policies, procedures and safeguarding incident records.

After the inspection
We continued to seek clarification from the provider to validate the evidence found. We looked at incident records and quality assurance records.

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 requires improvement. At this inspection the rating has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse, Assessing risk, safety monitoring and management, Preventing and controlling infection,

At our last inspection the provider had systems that were either not in place or robust enough to demonstrate safety was effectively managed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We identified that the provider was still in breach of this regulation as improvements had not been made or sustained.

- The provider had systems in place to safeguard people form the risk of abuse including the training of staff in how to recognise and report abuse, however the systems and processes were not applied effectively meaning that people were at risk of avoidable harm.
- People were not protected from poor practice and were at risk of harm. We observed one person receiving restraint, which did not match their assessed needs in their personal care plan. Restraint was not identified as an intervention for the person. This meant that the restraint was incorrectly used.
- Risk assessments showed people who needed two staff to support them at all times, did not always receive this level of support. This meant care had fallen below acceptable levels to meet individual needs or to keep people safe. The providers incident records showed that where support had fallen below people's assessed levels this had resulted in risks to people's safety.
- The assessing, monitoring and management of risk was not effective. Where people had restrictions of their freedom through restraint this was not always documented, monitored and did not trigger a review of the person's support plan. This information could be used to identify triggers or patterns of behaviour and subsequently develop effective management strategies to assist the person with their anxiety.
- People were not protected from the risks of infection. The registered manager had failed to take adequate steps to protect people from the risk of COVID -19. The local authority had informed us on 08 February 2022 that there was one person in the home who had tested positive for COVID-19. During our visit when we spoke with the registered manager, they were unaware that there was anybody with COVID-19 in the home and had failed to take effective infection control measures. We saw visiting contractors enter and leave the area of the home where the person with COVID-19 lived without observing safe use of PPE. The contractors did not consistently wear masks and effective hand hygiene was not undertaken as they moved from area to area. We raised our concerns with the registered manager and they immediately took action to ensure infection prevention and control measures were followed.

Care and treatment was not always provided in a safe way and risks to people's safety was not managed

effectively. The provider failed to ensure that risks relating to infection control and the transmission of COVID 19 were being effectively managed. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely, Learning lessons when things go wrong

● Medicines information for staff to follow was not stored in a way that was clear and easily accessible. People had individual protocols and information for PRN (as necessary) medication for example pain, anxiety or epilepsy seizure management. This provided information for staff on when to safely give these medicines. Although staff did not raise concerns with us over administering medicines, information was not always easily accessible as protocols were on a different system to the prescribed medicines information, it meant that all relevant individual medicine information was not stored together increasing the risk of errors or inconsistent administration.

● The management of medicines was not always safe. We identified the medicine administration record (MAR) was not always accurate. There was an entry in one person's record with an unrecognised code against a PRN (as required) medicine. The registered manager could not tell us what the code meant, or if the medicine had been given. The registered manager told us that there were a high number of medicines errors, and told us, "I am yet to drill down into why." From the 'safeguarding/cause for concern' records shared with us by the provider there had been thirty three recorded medicine errors during 2021 and two medicine errors in January 2022 where one person had been given twice the dose of PRN medicines as prescribed, and one incident where a person had missed their complete prescribed lunchtime medicines.

● The registered manager could not show us how the service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. The registered manager could not assure us that they understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured that people's medicines were reviewed by prescribers in line with these principles

The failure to ensure lessons were learnt and actions taken to ensure that the management of medicines was safe was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● We were assured that the provider was accessing testing for people using the service and staff.
● The provider was supporting visits in line with the Government's guidance.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.

The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

Staffing and recruitment,

● People were not getting appropriate support because people who were assessed as needing 1:1 or 2:1 care, were not always receiving the identified level of support to keep them safe. We saw entries in records identified where people not receiving their assessed level of support, had resulted in incidents which had placed people at risk of harm. The provider told us recruitment had been ongoing, but the impact of COVID-19 and staff leaving had meant a curtailing of people's 1:1 or 2:1 care, leaving people at risk of harm or neglect.

● Systems for deployment of staff were ineffective. For example, on 14 February 2022 a team leader allocated staff to support the individual people in the area they were responsible for. However, shortly after two allocated staff members were moved to support on another area of the home. This left the team leader two staff short of the planned allocation and the team leader told us this level was below what they identified as being a safe level on this living area. We discussed this with the registered manager they were unaware of how the staff had been delegated duties for that day. The registered manager referred to documents which did not reflect where staff had been deployed to work.
● The provider had not ensured sufficient staff had the competence, skills or experience to provide safe care, putting people at risk of unsafe practice. Staff were implementing physical restraint and behaviour management they had not been trained for in line with the provider's policies and procedures. Two staff we spoke with confirmed they had not received any training. Records shared with us by the provider following our visit, identified thirty separate physical incidents requiring restraint that were reported between 01 January 2022 and 14 February 2022. These incidents involved forty-five staff members but sixteen of these staff had not had any restraint or behaviour management training.

The provider had failed to ensure sufficient numbers of skilled and experienced staff to ensure people received the appropriate level of support to meet their needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had a recruitment system that ensured only suitable staff were employed. Staff applications contained reference checks on previous employment and also checks with the Disclosure and Barring Service (DBS). 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.

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 requires improvement. At this inspection the rating has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At the previous two inspections we found systems were either not in place or robust enough to demonstrate the service was being effectively managed. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found not enough improvement had been made and the provider was still in breach of regulation 17.

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

● The culture of the service did not meet national policy or best practice for supporting people with a learning disability. Care and support did not promote an approach that empowered and included people in their own care. One person told us how they had not gone out for "a number of years." There was no evidence of people had been involved in reviews of their care.
● Systems and processes failed to identify inappropriate use of restraint, staff had not had the required training or followed approaches in line with least restrictive practice.
● The provider's systems were ineffective in mitigating risks to be people, putting them at risk of escalating behaviours. For example, one person's care records identified "Perhaps the lack of staff presence that led up to the behaviours could have been a trigger." However, the staffing contingency plan which was not dated identified this person would continue to drop below their identified 1:1 support. The registered manager told us the contingency plan was out of date, and they did not know when it was written or reviewed.
● The provider's systems and processes were ineffective and failed to identify concerns found on this inspection. This included a failing to mitigate and monitor risks to the health, safety and welfare of service users and others.
● The provider's systems failed to ensure that relevant authorities were notified in a timely manner of where service users were at risk of harm. The incident of restraint that was witnessed by the inspectors had not been recorded on any incident form or care records and no action taken to notify the safeguarding authority.
● The provider and registered manager did not have oversight of how safe or effective interventions were with the people under their care. The registered manager was unaware of incidents of poor practice or where physical intervention had been used. When we spoke with the registered manager on 14 February 2022 they were unaware of the incident of restraint that was witnessed by two CQC inspectors on the 11 February 2022.
● The provider did not have effective communication systems to ensure that people in the service who

needed to know important information to keep people safe had the required level of information. When we spoke with the Registered Manager on 09 February 2022, they were not aware that a person had tested positive for Covid-19 following routine PCR testing on 3 February 2022, and as a result had failed to take effective action to prevent the spread of the infection.

This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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, Working in partnership with others

- Systems were not in place to ensure safeguarding incidents were consistently shared with the local authority to allow investigation of people's safety. The lack of reporting to relevant agencies led to a lack of external oversight and promoted a closed culture.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider did not encourage people to be involved in the development of the service.
- The provider had not sought feedback from people, relatives and those important to them to develop the service.

Continuous learning and improving care

- The lack of governance and oversight by the provider and management team did not promote change, improvement or learning from when things went wrong.

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 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure sufficient numbers of skilled and experienced staff to ensure people received the appropriate level of support to meet their needs. 18(1)

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 Care and treatment was not always provided in a safe way and risks to people's safety was not managed effectively. The provider failed to ensure that risks relating to infection control and the transmission of COVID 19 were being effectively managed. There was a failure to ensure lessons were learnt and actions taken to ensure that the management of medicines was safe. 12(1)(2)(a)(b)(c)(g)(h)

The enforcement action we took:

serve a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not in place to assess, monitor and improve the quality and safety of the service provided, and assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others. Regulation 17, (1)(2)(a)(b)(c)(f)

The enforcement action we took:

Issue a warning notice