New Outlook Housing Association Limited

Tulip Gardens

Inspection report

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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

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
Tulip Gardens is a residential care home providing personal care to eight people at the time of the inspection. The service can support up to eight people some of whom are living with physical disabilities, learning disabilities, sensory impairment and autism.

People's experience of using this service and what we found
Based on our review of Safe and Well led the service was able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right Support:
People had not always had the risks associated with their care assessed, monitored and mitigated.
The provider had not always ensured incidents were reviewed to reduce the chance of reoccurrence and take learning from them.

The service gave people care and support in a safe, clean, well equipped, well-furnished and well-maintained environment that met their sensory and physical needs. Staff communicated with people in ways that met their needs. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff supported people with their medicines in a way that promoted their independence and achieved the best possible health outcome.

Right Care:
Staff understood how to protect people from poor care and abuse. The service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

People could communicate with staff and understand information given to them because staff supported them consistently and understood their individual communication needs.

The service had enough appropriately skilled staff to meet people's needs and keep them safe.

Right Culture:

Systems and processes to monitor the quality and safety of the service had not always been effective.

Staff placed people's wishes, needs and rights at the heart of everything they did. Staff felt well supported in their role, felt able to raise any concerns and enjoyed their roles in supporting people who lived at the service.

People and those important to them were involved in planning their care. The service enabled people and those important to them to worked with staff to develop the service.

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 25 August 2018).

Why we inspected
We undertook this focussed inspection as part of a random selection of services rated Good and Outstanding.

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 Good to Requires Improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well Led sections of this 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.

Enforcement
We have identified breaches in relation to how incidents and accidents were managed and in how the systems at the service enabled oversight and monitoring.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The 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.

Tulip Gardens

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
Two inspectors visited the service on the 30th August 2022. One assistant inspector carried out phone calls to relatives on the 31 August 2022.

Service and service type
Tulip Gardens 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. Tulip Gardens is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 30 August 2022 and ended on 22 September 2022. We visited the location's service on 30 August 2022.

What we did before the inspection
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 information gathered as part of monitoring activity that took place on 19 May 2022 to help plan the inspection and inform our judgements. We sought feedback from the local authority. We reviewed information we had received about the service since the last inspection. We used all this information to plan our inspection.

During the inspection
We spoke with five relatives and two people who used the service. We spoke with five staff including the registered manager and four support workers. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed three people's medication records and two people's care plans and risk assessments. We viewed two staff recruitment files and the processes around staff recruitment. We reviewed staff training information and documents relating to how the service was monitored.

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 Good. At this inspection the rating has changed 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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
- Where people had experienced incidents or accidents, we found there had not always been an investigation into how these had occurred.
- There was no accident or incident analysis carried out both at a person or service level and opportunities to identify trends were lost. It was unclear in places what action had been taken, following an incident, to review the event. It was also unclear what measures had been put in place to reduce the risk of a similar incident occurring again.
- Where people had sustained injuries following an incident, care plans and risk assessments had not always been updated to reflect this and to ensure risk mitigation was in place.
- In some instances, staff had determined action to take to reduce risks to people. This information was not consistently recorded in the persons care plan.
- Where health professionals had recommended exercises following an injury these had not been incorporated into the care plan and it was unclear if these exercises were being carried out, if they had been reviewed and if they had been successful.

Systems to review incidents or accidents were not effective. This was a breach of Regulation 12 (2)(b)(Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Whilst improvements were needed around incident and accident management, we found other risks to people's care had been assessed and mitigated appropriately. This included clear guidance around people who were at risk of choking.
- Where incidents or accidents occurred, immediate action was taken to ensure the safety of the person and or to seek medical attention. The registered manager ensured the appropriate authorities were informed following an incident.
- Staff managed the safety of the living environment and equipment in it well through checks and action to minimise risk.
- Staff knew the risks associated with people's care and relatives we spoke with felt their loved one was safe at the service and that staff knew people well.

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.
● For people that the service deemed as lacking the capacity to make a specific decision, staff clearly recorded assessments and any best interest decisions.

Using medicines safely
● We noted that further detail was needed in 'as required' medicine protocols where variable doses were present. For example, some people had been prescribed one or two tablets 'as required'. There was not sufficient detail to provide guidance for staff of which dose to give and in what circumstances. Systems in place had not identified this.
● People were supported by staff who followed systems and processes to administer, record and store medicines safely.
● Staff had received training in medicine administration and had checks carried out on their competency to ensure they were safe to support people with their medicines.
● There were checks in place to monitor medicine administration that were carried out at various intervals during the month. The registered manager maintained oversight of these checks.

Staffing and recruitment
● Staff recruitment and induction training processes promoted safety, including those for agency staff. Staff knew how to take into account people's individual needs, wishes and goals.
● The service had enough staff, including for one-to-one support for people to take part in activities and visits how and when they wanted.
● Regular agency staff were being used to ensure safe staffing levels were in place. The registered manager was working hard to fill the staffing gaps with permanent staff through constant recruitment.

Systems and processes to safeguard people from the risk of abuse
● Staff were aware of the correct processes to follow in relation to safeguarding people living at the home. They could inform us about the signs they would look out for that may indicate that a person had experienced abuse.
● Staff had received training on how to recognise and report abuse and they knew how to apply it.
● Where safeguarding concerns had been identified the registered manager had notified the appropriate authorities for investigation.

Preventing and controlling infection
● We were somewhat assured that the provider's infection prevention and control policy was up to date. The policy did not contain the most up to date government guidance and required updating. For example, the policy did not include the most current guidance on when staff should wear a face mask. Whilst the policy required updating, we did not find evidence that suggested this was impacting on the steps staff were taking in relation to infection control. The registered manager informed us this would be actioned.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.
● 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.

Visiting in care homes
● Relatives informed us they were supported to visit their loved ones. The provider followed the latest government guidance in relation to visiting arrangements.

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 Good. At this inspection the rating has changed to 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Systems were not in place to review incidents across the service to identify potential themes or additional learning and to prevent reoccurrence. Additionally, systems to ensure care plans and risk assessments were accurate were not effective as risk mitigation around falls was not sufficiently recorded.
- Oversight of care plans had not identified that one person's information relating to care decisions was in another person's file. In addition, communication from a health professional in relation to a directive had not been updated in the person's file. This was rectified on the day of the inspection.
- Systems had not been effective at identifying that important information about changes to a person's needs had not been discussed during reviews of care.
- Monitoring systems had not identified missing information in a seizure protocol written by the service. Whilst staff knew the person and appropriate action to take, it was important for staff guidance to be accurate and complete, particularly as the service was currently using agency staff to support people.
- Monitoring checks had not identified where further detail was needed in protocols for as required medicines where variable doses were present. Further clarity was needed to ensure staff had clear guidance of when to give what dose.
- Systems to monitor the service were not always effective. The registered manager completed a comprehensive audit covering many areas. This audit had not identified the areas needing improvement and in some places was incorrect.
- The provider had not ensured their statement of purpose had been kept up to date. We found they were supporting people whose needs were not on their original service user bands at the point of registration.

Systems were not robust enough to demonstrate effective monitoring of the quality and safety of the service. This was a breach of Regulation 17 (2)(a)(b) (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager had begun work to address the issues found at the inspection and health professionals had been involved to support one person at risk of falls following the inspection.

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

- People we communicated with during the inspection indicated they were happy living at the service.
- Relatives shared positive feedback about the support their loved ones received. One relative told us, "I

know that she is happy here and has always been happy here." Another relative told us, "We know she is happy here because her face lights up when staff enter the room." This relative also told us, "I am relieved and happy that [name of person] is at Tulip Gardens.". Another relative told us that the staff team, "Show a lot of love and care."

● Staff members showed warmth and respect when interacting with people. People were involved in discussions about their care and people were greeted as staff entered communal areas of the home.

● Staff had a good knowledge of the people they supported and what was important to them. Staff enjoyed supporting the people living at the home. One staff member told us the best part of their role was, "To be able to help and make a difference to the people that live here." Another staff member told us, "It's the bond you form with the service users. They are putting their trust in us and we promote independence and support them with things they need support with."

● Staff felt respected, supported and valued by the registered manager. One staff member told us, "[name of registered manager] has been brilliant."

● Management were visible in the service, approachable and took a genuine interest in what people, staff, family, advocates and other professionals had to say. One relative told us, "The manager is setting a sterling example for her staff. I think it has very good management."

● Management and staff put people's needs and wishes at the heart of everything they did.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager and staff gave honest information and suitable support, and applied duty of candour where appropriate.

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

● People had been involved in their care plans and meetings took place with people on a monthly basis to review their care. We noted these reviews had not always discussed key events that had occurred for people and recorded conclusions.

● Relatives felt involved in their loved one's care. One relative told us, "They always keep me informed and let me know how she is." Another relative told us, "It is her home and they do lovely things for her. For example, on her 70th birthday they did a party for her."

● The provider sought feedback from people and those important to them and used the feedback to develop the service.

● Staff meetings took place to enable key messages to be shared and for discussions between the staff team about any further improvements that could be made.

Working in partnership with others

● The registered manager and staff worked with other health professionals to escalate concerns and to ensure people received appropriate support that enabled good health and well-being.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure incidents and accidents were reviewed sufficiently to mitigate further harm. Regulation 12 (2)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure robust and effective systems were in place to monitor the quality and safety of the service. Regulation 17(2)(a)(b).