Independence with Care Ltd

Worstead Lodge

Inspection report

106 Cromer Road
North Walsham
Norfolk
NR28 0NB

Tel: 01692403865

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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

About the service
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.

Worstead Lodge is a residential care home providing accommodation for persons requiring nursing or personal care to up to 20 people. The service provides support to autistic people and people with a learning disability. At the time of our inspection the home supported 19 people. 8 people lived in an adapted detached house, while 11 people lived in smaller self-contained flats and bungalows on the premises, sharing with 2 or 3 others. The provider company had changed ownership in April 2023, however this did not require any changes to the provider's registration with CQC.

People's experience of using this service and what we found

Right Support:
People were generally happy living in Worstead Lodge and many had lived there for a very long time. However, recent changes brought about by the change of ownership of the provider company had destabilised the support people received and left them feeling vulnerable and ill-at-ease in their home.

People were at risk of not receiving safe care. People's personal care and support records did not always reflect their needs, and some documents had been destroyed leaving newer and agency staff without the guidance they needed to support people safely. Medicines were not always administered safely. Maintenance checks were regularly undertaken and emergency plans were in place.

The home was larger than that indicated by best practice guidance, however this was mitigated in part by the inclusion of smaller, self-contained flats and bungalows within the care home's grounds.

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.

Right Care:
Staff were not always effectively deployed to ensure people received person-centred care. The systems in place did not always protect people from financial abuse. Staff were kind and caring in their interactions with people and people were comfortable with the staff they knew well. Staff were recruited safely and had been appropriately trained.

Right Culture:
A closed culture had developed in the home due to a lack of management oversight, however the provider had taken appropriate action as soon as they had become aware of this. A new management team had been very recently appointed and a new position created to improve oversight of the support people received. New systems had been introduced however these had not yet been fully implemented so we could not be assured of their effectiveness at the time of our inspection. The new management team were committed to improving 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 21 December 2021).

Why we inspected
We received concerns in relation to safeguarding, staffing, management of medicines, and the leadership and governance of the service. 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 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 full report.

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 inspection reports and timeline' link for Worstead Lodge on our website at www.cqc.org.uk.

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.

Worstead Lodge

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
This inspection was conducted by three inspectors, a member of the CQC medicines team and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had very recently started in post and had started the process to apply to register with CQC.

Notice of inspection
This inspection was unannounced on the first day. We undertook an out-of-hours visit on 11 January that was also unannounced. The third visit of the inspection was announced.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection from commissioning local authorities, relatives of people who use the service and staff working there. We reviewed notifications of important events the service is required to send to us and other information we held such as safeguarding records.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We spoke with 11 people who use the service. An Expert by Experience spoke with 4 people's relatives over the telephone. We observed how people interacted with staff in communal areas and some aspects of care and support staff provided. We reviewed people's personal care and support records, staff recruitment records, staffing rotas and staff training records. We reviewed medicine administration and associated records for 10 people, observed people receiving their medicines and spoke with 3 members of staff about medicines. We reviewed records relating to the management of the service such as audit records, safety checks and emergency plans.

We spoke with 5 care workers, the activities coordinator, the maintenance coordinator and 1 volunteer who spends time at the home. We spoke with 5 members of the management team including the home manager, deputy manager, the provider's regional support manager, the director of the provider company and the provider's operations director who is also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

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.

Systems and processes to safeguard people from the risk of abuse

- The provider had not operated effective systems to ensure people were safeguarded from the risk of abuse.
- A recent situation demonstrated that the provider's system in place to prevent financial abuse had not been robust, and people and their relatives told us of the profound impact this had on them. One person said, "I don't know what's going on with my money. This is all making me very anxious." Another person told us, "I was devastated. My heart was broken and I couldn't sleep. How can people be so cruel?" A relative said, "[My relative] was miserable when [they] came home over Christmas. When I asked why [they] mentioned that [their] money was missing and [their bank card] had been declined when [they] tried to pay for milk. This was devastating for [their] self-esteem."
- The previous home manager had not referred incidents to the local authority safeguarding team for investigation, nor appropriately notified CQC of allegations of abuse. The new management team had rectified this by making referrals when appropriate and notifying CQC as required. They had also developed a new system to better protect people from financial abuse, however this had not yet been fully implemented at the time of our inspection.

Although the provider had taken action to address the most significant concerns, people had not been protected from abuse and the provider's systems had not been operated effectively, with appropriate oversight. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had been trained in safeguarding. They knew how to identify abuse and to report incidents and concerns to the management team and to other agencies. There was contact information available on the noticeboards within the home for staff to report concerns.

Staffing and recruitment

- Although the provider usually ensured there were enough staff on shift to support people safely, staff were not always deployed effectively to ensure people's needs were met and their rights protected. Due to vacancies, the service used some agency staff who didn't always know people and their needs well.
- Some people who used the service needed support with daily living tasks such as shopping, cleaning and laundry. Staff were not always available to support people effectively with these tasks. A person told us, "I have been left off the [staffing] rota for shopping, sometimes for weeks. They forgot about me. I have had to go without." Another person said, "I don't have support to clean, I do it all myself." This person's relative told us, "I've had to speak with the staff as the home isn't clean. As well as cleaning their flat [my relative and

their flatmate] are responsible for shopping and cooking but they are really struggling as there is a lack of support from staff."
● People also told us about the impact the high rate of staff turnover had on their support. One person said, "My keyworker left and I haven't had one for a long time. I really need a keyworker, I have been asking for one." Relatives told us, "There are a lot of new staff, previously there was a steady staff group. They don't know [my relative] and [their] needs well", "The staffing situation is impacting on how [my relative] is supported", and "There have been a lot of staff changes and I don't feel confident that the staff know [my relative], and they seem to think [my relative] is more able than [they are]."

The provider's failure to ensure enough skilled, competent and experienced staff were deployed effectively to meet people's needs was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● The manager planned a recruitment campaign to fill staffing vacancies. They told us about the values and positive characteristics they expected staff to have to effectively support people.
● Professionals who worked with the people who use the service and staff had told us of a recent occasion when there had not been enough staff on shift to support people safely. The management team had developed a comprehensive contingency plan to address staff shortages during shifts as a result.
● The provider operated a safer recruitment system. Staff were appropriately checked before they started work and the provider required references, a full employment history and a DBS check. 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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Although risks relating to most people's support had been assessed, many records were not available to guide the support staff provided to people. Records had been destroyed.
● Staff who had worked at the home for a long time knew people and their needs well and could mitigate any risks associated with people's support, however the recent high turnover of staff and use of unfamiliar agency staff left people at significant risk of not being supported safely in ways that met their needs.
● The accident and incident reporting system in place had been ineffective. Although staff reported incidents to the previous home manager, these were not appropriately recorded, investigated or action taken to prevent reoccurrence.

Using medicines safely
● Medicines had not been managed safely. Records were missing and there were discrepancies and gaps in people's medicine administration records (MARs). There were no recent records of when medicines were unused and disposed of at the service. Some medicines in stock were not recorded on people's MARs.
● Staff handling and administering people's medicines had recently had their competence checked. However, we observed that medicines were given to people in a busy area of the home by staff who were frequently interrupted with the potential for making errors. We noted that for one person staff had regularly prepared their medicines into a secondary container for use. This was unsafe practice.
● Some information available to staff to assist them to give people their medicines was potentially misleading. This included information about people's medicine sensitivities and their topical medicines. Body maps for people's topical medicines were not always in use or properly completed. A person who had been prescribed a medicated skin patch did not have the application site sufficiently varied to avoid potential skin effects.
● People living at the home did not always receive regular reviews of their medicines by prescribers in line with national guidance.

● The manager told us that recent records of medicine errors and incidents had been removed and were no longer available. Therefore, the service was unable to provide evidence that there were processes in place to handle and oversee medicine errors and incidents in a way that would lead to improvements being made.

The provider's failures to ensure care and support were delivered in a safe way, as described in the above 8 points, were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Reassessing risks and ensuring there were clear risk assessments and care plans in place for people was a high priority for the manager. They told us, "We have to start from the beginning." People had comprehensive, up-to-date personal emergency evacuation plans in place and fire drills were undertaken regularly, at different times of the day and night.
● The new management team had implemented a more robust incident and accident reporting system. A relative told us, "There have been some very positive changes. They have introduced incident reporting."
● The deputy manager took immediate action to address the most significant concerns we identified relating to safe medicines management. By the second visit of our inspection, they had improved the recording system, arranged medicines reviews with prescribers and worked with care staff to improve their practice and the dispensing pharmacy to make better arrangements for medicines disposal.
● Maintenance checks were undertaken and action taken when issues were identified. Records showed there was a system of daily, weekly, monthly and quarterly checks. The maintenance coordinator told us, "Things are a lot better now. I used to not get the resources I asked for – even lightbulbs when they blew – but now I ask for what I need and get it." They had also designed a rolling redecoration and maintenance plan that had very recently been started.

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 had recently applied for authorisations to ensure people's rights were protected by DoLS, where this was necessary to ensure people's safety.
● Staff had been trained in MCA and DoLS and respected people's capacity to make choices.

Preventing and controlling infection
● The provider had systems in place to ensure people were protected from the risks associated with infection.
● There was a COVID-19 risk assessment and an infection prevention and control policy in place. Staff used appropriate PPE and there was plenty of PPE available.
● Records showed that areas of high risk such as bathrooms and the kitchen in the main house were checked regularly and action was taken to prevent infection in these areas. Colour-coded chopping boards and mops were used to reduce the risk of cross-contamination.
● However, we observed and received feedback from professionals and people's relatives that some areas

of the self-contained bungalows and flats were not clean. A service had been engaged to undertake deep cleans of these areas and we will check on the provider's progress to ensure this is maintained at our next inspection of the service.

Visiting in care homes

● The provider facilitated visits to the home. People told us their friends, relatives and other people important to them were able to visit whenever they wished.

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.

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; Continuous learning and improving care

- Although people had lived at Worstead Lodge for a long time and told us they were generally happy with the support they received, recent changes of ownership and management and a lack of effective management oversight had result in a closed culture developing. The provider company changed ownership in April 2023.
- People, their relatives and staff told us about how this had affected them. A care worker said, "It has been an upheaval, quite traumatic and unsettling. I hope we can get back to how things should be." People's relatives told us, "It's been poor since Crossroads took over with a series of managers being appointed and not staying very long", and "It doesn't feel like a home at the minute."
- Although audits and checks had been carried out, these were not an accurate reflection of the operation of the service and action had not been taken to improve. Regulatory requirements were not met.
- Management oversight of the operation of the service had not been comprehensive or robust. Some people's personal care and support records were not available to staff to guide the support they provide.

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

- The closed culture that had developed within the home had disempowered people, their relatives and staff.
- People told us, "We used to have meetings to talk about things. They were good but we stopped", and "I don't have a say. No one asked me if I wanted [my flatmate] to move in but I like them, it's ended up ok." A person's relative said, "No, I don't feel involved in the running of the home. I've not been informed if changes have been made as a result of raising my concerns." Another person's relative told us, "I don't feel listened to. Although I have raised issues, I don't feel matters are listened to properly and they are not resolved."
- Staff told us about how they had tried to report concerns but had been actively stopped by the previous manager.

The provider's failure to operate effective systems to assess, monitor and improve the quality and safety of the service provided, as well as to seek and act on feedback and to maintain accurate records, were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The new management team had taken appropriate action to start addressing the concerns as soon as

they became aware of them. They recognised they had a lot of work to do to rebuild a positive culture that achieves good outcomes for people and regain the trust of people who use the service, their relatives, staff and professionals involved with the service. The manager told us, "We have an absolute willingness and commitment to get things right."

● The provider's nominated individual had very recently implemented a new management structure and provided additional management support to the new manager, including the appointment of a regional support manager. The team had developed a comprehensive system of audits and checks and had started working through a robust action plan.

● The management team planned a questionnaire for people who use the service, residents' meetings, relatives' meetings and staff meetings to support people, their relatives and staff to feel empowered and involved in the running of the home. The deputy manager told us, "It was absolutely a closed door with the last manager. I want to open it back up again and help people feel safe in their own home."

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 provider demonstrated they understood the duty of candour. The management team had apologised to people, their relatives and staff for recent events, and recognised the impact this had on people feeling safe and comfortable in their home.

Working in partnership with others

● The provider worked in partnership with others.

● Feedback from professionals who worked with the people who used the service was positive about the changes implemented by the new management team in a very short space of time.

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 failed to ensure care was provided in a safe way, by assessing, monitoring and mitigating risks; and ensuring systems were in place for the safe management of medicines. Regulation 12(1) and (2)(a), (b) and (g)

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 The provider failed to operate effective systems to safeguard service users from the risk of abuse. Regulation 13(1), (2) and (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems to assess, monitor and improve the quality and safety of the service people received; to maintain accurate records; and, to seek and act on feedback. Regulation 17(1) and (2)(a), (c) and (e)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider failed to deploy enough suitably qualified, competent, skilled and experienced staff to meet people's needs.

Regulation 18(1)