Partnerships in Care Limited

51 The Drive

Inspection report

Kingsley
Northampton
Northamptonshire
NN1 4SH

Tel: 01604710145
Website: www.priorygroup.com

Date of inspection visit:
06 December 2022
07 December 2022
12 December 2022

Date of publication:
19 January 2023

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
51 The Drive is residential care home providing care for to up to 3 people with a diagnosis of learning disabilities, autistic spectrum disorder or mental health needs. At the time of the inspection 2 people were living in the home.

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.

At the time of the inspection, the location did not care or support for anyone with a learning disability or an autistic person. However, we assessed the care provision under Right Support, Right Care, Right Culture, as it is registered as a specialist service for this population group.

People's experience of using this service and what we found
Right Support:
Risks to people had not always been assessed or mitigated. Risk assessments did not always contain the strategies required to reduce the known risks to people.

Medicine management required improvement. Records were not always kept up to date and staff told us that unsafe medicine practices had occurred.

People's care plans and risk assessments were not always kept up to date. We found incorrect information recorded and some areas were missing.

People were not always supported to have maximum choice and control of their lives and we could not be assured that staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Right Care:
The provider had not completed any investigation when people were found with unexplained injuries. Safeguarding procedures had not been consistently followed as unexplained injuries had not always been reported to the local safeguarding team.

Staff did not always have the information required to support people safely and, in a person-centred way. Issues with accessing the electronic care planning system meant at times staff had no access to people's care plans and risk assessments.

Staff did not always have sufficient training to meet people's individual needs.

People did not always know the staff, due to high levels of agency staff being deployed. Staff were safely recruited.

Infection prevention and control procedures needed to be followed to protect people from the risks of infection. Cleaning schedules were not consistently recorded as completed.

Right Culture:
Systems and processes were not effective in assessing, monitoring and reducing risks. Where improvements were needed these had not always been identified, due to audits either not being completed or not identifying the issues we found on inspection.

Staff did not consistently feel supported within the workplace.

Information was shared with relevant professionals and significant people. Feedback was sought from people who used the service and their relatives. Feedback was in the process of being reviewed.

The provider was open to feedback and put actions in place to mitigate concerns found on inspection.

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 6 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 improvements had not been made and the provider still in breach of regulations.

Why we inspected
We received concerns in relation to infection control and risk management. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

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.

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 not changed from requires improvement based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 51 The Drive on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safeguarding, risk management and oversight at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement

51 The Drive

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
The inspection was completed by one inspector

Service and service type
51 The Drive 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. 51 The Drive 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 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 a registered manager in post. However, they left the service on the first day of inspection and told us they were planning on deregistering with CQC.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority 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 1 person who used the service about their experience of the care provided. We spoke with 7 members of staff including the registered manager, directors, and care workers.

We reviewed a range of records. This included 2 people's care records and multiple medication records. We looked at 3 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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 changed 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; Learning lessons when things go wrong

At our last inspection the provider had failed to safeguard people from abuse and improper treatment. This was a breach of Regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of this regulation.

● People were at increased risk of abuse. Where people had an unexplained injury, investigations to establish what may have caused these injuries had not been completed. Therefore, mitigating strategies were not implemented to reduce the risk of future harm.
● The providers safeguarding policies and procedures were not consistently followed. Not all unexplained injuries had been safeguarded.
● Information had not been reviewed to identify and trends or patterns in people's injuries or when people experienced emotional distress. Records of people's distress had not always been documented. This meant mitigating strategies could not be implemented to protect people.

The provider had failed to safeguard people from abuse and improper treatment. This was a continued breach of regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong

At our last inspection the provider had failed to ensure a safe environment. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of this regulation.

● Risks had not been consistently identified or mitigated. We found known risks had no strategies identified to mitigate these risks. This put people at risk of harm as staff did not have information to provide safe care.
● Risks relating to people's health conditions were not fully recorded, there were no mitigating strategies or information for staff to understand the signs and symptoms that may require health support. This put people at risks associated with seizure activity.
● People were exposed to risks associated with fire. We found fire risk assessments had not been updated and actions from an external fire assessment had not been completed.
● People were at risk from hazardous substances. We found people had access to hazardous substances such as cleaning products.

● Medicine records required improvement. We found gaps on people's medicine administration records (MAR) that no reason recorded to evidence if this was a missed medicine or a missed signature. Staff told us that at times they did not have access to an up to date MAR. This put people at risk of not receiving their medicines as prescribed.
● Medicines were not always safely managed, as staff did not follow medicines policies or safe practices. A member of staff told us, "Staff have dispensed all medicines into pots or syringes (for liquid medicines) then left them in an unlocked cupboard for me to give later in the day." This put people at risk of receiving the wrong medicines.

The provider had failed to ensure risks to people's health and safety had been assessed and done all that is practical to mitigate those risks. The provider failed to ensure safe medicine management. These were a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider completed an action plan to mitigate the risks found on inspection. Mitigating strategies were implemented immediately after feedback.
● The provider had taken appropriate actions to minimise these risks within the environment such as securing heavy furniture, restricting window openings and monitoring of first aid kits.

Staffing and recruitment
● We found sufficient numbers of staff to meet people's needs. However, the provider was using a high number of agency staff, who did not always know people's individual needs. One person told us, "Staff are nice to me they do what I need, but we have had a lot of upheaval. I don't know most of the staff."
● People were supported by staff who had been safely recruited. Safe recruitment practices were in place and the provider used references and the Disclosure and Barring service (DBS) to ensure staff did not have any criminal convictions and were suitable to provide support for the people living at the service.

Preventing and controlling infection
● We were not fully assured that the provider was using PPE effectively and safely. On the first day of inspection we observed multiple staff not wearing appropriate PPE throughout the day. However, on the second and third day we observed improvements and staff wore PPE.
● We were not fully assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found gaps in the cleaning records. However, people told us staff did complete cleaning and the home appeared clean.
● 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 responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The provider followed government COVID-19 guidance on care home visiting. Visitors were given appropriate PPE as required.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best http://crmlive/epublicsector_oui_enu/images/oui_icons/cqc-expand-icon.pngavailable evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff support: induction, training, skills and experience; Staff working with other agencies to provide consistent, effective, timely care

- Staff could not consistently access people's care plans or risk assessments due to connectivity issues with the computer system used. Agency staff were unable to read care plans or risk assessments. One staff member told us, "I have never read a care plan, I have no information on [person's] communication needs." This meant staff could not access information to provide safe care.
- Care plans and risk assessments did not always contain up to date factual information. For example, one person's care plan had the wrong food texture, as it had not been updated with new guidance. This put people at risk of not receiving care and support in line with their assessed needs.
- Not all staff had up to date training to understand people's individual needs. The training matrix evidenced gaps in training for safeguarding, mental capacity, fire, infection prevention and control, behaviour that communicates distress, moving and handling and epilepsy. This put people at risk of not receiving safe care from staff who did not have the required knowledge and skills.
- Staff told us they had not received regular supervision or meetings to share information, discuss concerns and to gain support within their roles. One staff member told us, "I haven't had a supervision for over 7 months, I have no way of raising any niggles I may have. I haven't felt supported."

The provider had failed to ensure staff had the information, skills and knowledge to support people safely. was were a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
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 MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA , whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The provider had not always assessed people's capacity for specific decisions. One person did not have a mental capacity assessment completed to assess their capacity to consent to staff completing a personal care task. Another people did not have a mental capacity assessment completed to assess their capacity in relation to having a relationship.
● When people had been assessed as lacking the capacity to make specific decisions, there were no best interest decisions recorded. This meant people were at risk of not receiving care with the least restrictive option.

The provider had failed to ensure systems and processes followed the Mental Capacity Act 2005. This was a breach of regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support
● We could not be assured people were supported with healthy eating. One person told us, they had choice over their meals. However, records showed the oven had not been used in November 2022 . There was no evidence this person received cooked meals.
● People were supported to access the doctor, optician and dentist as required.
● People had hospital passports which were used by health and social care professionals to provide the necessary information support them people in the ways they needed.
● Staff recorded any support required with people's oral health.

Adapting service, design, decoration to meet people's needs
● The living room did not have any curtains at the windows. One person told us, "We need curtains to close at night and keep the room warm." The house faced onto a street which meant people could look into the house and people did not have privacy in their living room.
● People's bedrooms were personalised and decorated to individual preferences. One person told us, "I like my room, it is how I like it."
● The house had a sensory room. This room was used by people to relax in a calm sensory environment.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

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

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

At our last inspection the provider had failed to ensure systems and processes were robust enough to effectively manage safety. This was a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of this regulation.

● Systems and processes were ineffective in ensuring staff had the information, skills and knowledge to meet people's needs safely. No actions had been taken to rectify the concerns with staff not being able to access care plans or risk assessments. One member of staff told us, "Our training is not properly monitored, I know I am overdue on some training courses, but no one has told me or allocated the courses to me."
● Systems and processes were not in place to ensure injuries had a cause recorded or had been investigated to implement mitigating strategies. This put people at potential risk of abuse.
● Systems and processes were ineffective in ensuring safe management of medicines were in place and followed.
● Systems and processes to identify risk to people from the environment were ineffective. We found risks associated with fire and people accessing hazardous substances.
● Audits on kitchen and food safety had not identified the concerns we found with missing records of cooked food temperatures and fridge temperatures.
● Systems and process to ensure people had mental capacity assessments and best interest decision recorded when appropriate was not in place. We found people did not have best interest decisions recorded

● Staff told us they did not always feel valued or supported within the workplace. Staff did not have the assurances their concerns remain confidential. One staff member said, "I raised an issue but the next day everyone knew. They [senior staff] had told everyone, nothing is confidential. I think they need to improve on supporting staff." Staff had not received regular supervisions.

The provider failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality of the service. This was a continued breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider completed an action plan to reduce the risk of harm to people and to identify mitigating strategies. New systems and processes were being implemented.

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

● Staff did not feel involved in making improvements to the service. One staff member said, "I have made suggestions, but I don't feel listened to."

● The provider sent out an annual survey to people and staff to gain their views on the service delivered. However, the results were for multiple services and not specific to the home. One staff member told us, "We sometimes get emails from [the provider] like questionnaires, but they are not specific to 51 The Drive."

● One person told us they could have a 'house meeting' at any time to discuss and concerns, improvements or suggestions.

Continuous learning and improving care; Working in partnership with others

● The provider was engaged and open to the inspection process and remained open and transparent throughout.

● People and relatives were involved in the care planning process and stated they were involved in regular reviews of care.

● The provider worked with commissioners to support people transitioning in or out of the service.

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 understood their responsibility under the duty of candour. The duty of candour requires providers to be open and honest with people when things go wrong with their care, giving people support and truthful information.

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 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure systems and processes followed the Mental Capacity Act 2005.

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 The provider had failed to ensure staff had the information, skills and knowledge to support people safely. The provider had failed to ensure risks to people's health and safety had been assessed and done all that is practical to mitigate those risks. The provider failed to ensure safe medicine management.

The enforcement action we took:

Warning Notice

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 had failed to safeguard people from abuse and improper treatment.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality of the service.

The enforcement action we took:

Warning Notice