Assistants at Hand (South West) Ltd

Accommodation with Assistants at hand

Inspection report

69 Hill Park Crescent
Plymouth
PL4 8JW

Tel: 07796263488
Website: www.assistantsathand.com

Date of inspection visit:
23 January 2022

Date of publication:
16 March 2022

Ratings

Overall rating for this service	Inspected but not rated

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

Summary of findings

Overall summary

About the service
Accommodation with Assistants at Hand is a residential care home providing personal care for to up to 11 people in one adapted building. At the time of our inspection there were 6 people using the service. The registered manager and provider are the same person.

People's experience of using this service and what we found
People did not have care plans which meant risks associated with people's care had not been identified and could not be managed safely. Medicines management was not based on current best practice which exposed people to a significant risk of harm and/ or not receiving their medicines as prescribed. Some medicines were not stored safely.

People were not always protected from the risk of avoidable harm because the risks associated with people's care were not assessed or managed. The environment and the premises were unsafe and as a result we made an alert to the fire service.

Safeguarding systems and processes were not followed. The registered manager (who was also the registered provider) did not always report and investigate safeguarding concerns. As a result of this inspection we made a safeguarding referral to the Local Authority to ensure one person was safely protected from harm.

The providers oversight and governance of the service was inadequate, Systems were either not in place or not operated effectively. Serious failings in relation to safety and quality had not been identified or addressed.
For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This service was registered with us on 13 November 2020 and this is the first inspection.

Why we inspected
The services first inspection was brought forward because we received concerns in relation to people's safety and the management and leadership within the service. As a result, we undertook a focused inspection to review the key questions of safe 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.

We wrote to the provider following our inspection asking for an action plan on how they would keep people safe. The provider responded, however we were not fully assured that appropriate action had been/ would

be taken to mitigate the risks significant risks we identified.

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

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

We have identified three breaches in relation to safety and the quality of the service.

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 continue to work with the local authority to ensure people's safety. The provider has taken the decision to de register this service.

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.

Accommodation with Assistants at hand

Detailed findings

Background to this inspection

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

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 team was made up one inspector.

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

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed the information, we held about the service, including notifications we

had received. Notifications are changes, events or incidents the provider is legally required to tell us about within required timescales. We sought feedback from the local authority. We used this information to plan the inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spent time with and spoke with four people living at the service, two relatives, two members of staff and the registered manager. To help us assess and understand how people's care needs were being met. We requested key records relating to peoples care needs and the day to day running of the service. These were not made available to us as requested during the site visit. To date we have not received these records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with four health care professionals, a representative from Plymouth City Council's quality assurance and improvement team (QAIT) and safeguarding team and two relatives.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection of this newly registered service. This key question has been rated 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

- Relatives we spoke with told us people were not safe living at the service.
- The registered manager had failed to ensure people were adequately assessed as requiring equipment to reduce the risks associated with their care. We observed one person who was in an unsafe position whilst lying in bed. We asked the registered manager if this person had been assessed as needing either bedrails or a safety mat. The registered manager told us 'not on paper'. This meant the person was at risk of injury from falling out of bed.
- Risks associated with people's on-going health needs, were not managed appropriately. The registered manager had failed to ensure adequate risk assessments had been completed for people who were risk of falling, choking and dehydration. This meant staff could not be guided in providing safe and effective care.
- One person had diabetes. This person did not have a specific care plan in place to guide staff in supporting the person appropriately and when to seek urgent medical advice. This put the person at significant risk of harm.
- People were not kept safe from risks associated with the environment in which they were living. Windows in every room were unrestricted. The registered manager was not aware that the absence of suitable window restrictors was not in line with health and safety executive best practice guidance.
- Radiators throughout the service were uncovered and hot to touch. The Registered Manager was not aware of the need for radiator covers and/or radiator guards. This put service users at risk of being burnt.
- During our inspection we noted bottles of bleach and anti-bacterial cleaning products were left unattended and unsecure in parts of the service. Risk assessments had not been completed to determine the risk this posed and the actions needed to manage the identified risk. Some people were showing early signs of dementia.
- The Provider had not carried out a fire drill since the service was registered on 13 November 2020. This was further confirmed in writing by the Registered Manager following the inspection. This put people at significant risk of harm or death in the event of a fire.
- There were no fire risk assessments or personal evacuation plans within the service. There was not adequate equipment to ensure the safe moving of service users in the event of a fire. Service users on the top floor had no access to emergency evacuation equipment. This exposed service users to an increased risk of harm in the event of a fire. This health and safety failure resulted in an alert being made by CQC to the fire service.
- People were not always able to call for help if they needed it. The system used for people to call for assistance was either not being used appropriately by staff or people did not have access to a call pendant. One person on the top floor had no call for help facilities in their room. When we asked them what they

would do to call for help, they said they would "shout out". We saw on two occasions where a person called for help using their pendant alarm and neither staff member on duty had the device on them that registered the call for help. We fed this back to the registered manager so they could address it promptly. This placed people at risk of not being able to be supported in a timely way if they were in distress or needed assistance.

Using medicines safely

● Medicines were not in all cases stored safely. During our inspection we observed an incident where a controlled drug could not be accounted for. This controlled drug was later found by staff in an unlocked cupboard in a communal kitchen.

● One person was prescribed medicine which needed to be stored at a low temperature. We found this medicine stored in a paper bag in a food fridge accessible to other people. On two occasions during the inspection a health care professional found medicines left lying unattended on the floor and in a cupboard within the service.

● These concerns relating to medicines placed people at risk of harm and/ or not receiving their medicines as prescribed.

The concerns we identified in relation to risk management and medicines management was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The system for recording administration of medicines was not effective. Where administration of medicines had been recorded there were gaps and errors in these records. This meant the provider could not be assured medicines were administered as prescribed.

Learning lessons when things go wrong

● Systems were either not in place or robust enough to demonstrate accidents and incidents were effectively monitored and reviewed.

● The findings of our inspection identified a culture that was not based on learning. We found actions the provider told us they were going to take before the inspection had not been completed. Further, where medicines concerns had arisen, despite feedback from healthcare professionals, the same mistakes were being made.This showed the provider had not learned from the concerns. This meant that when things had gone wrong, the potential for re-occurrence was inevitable because there was no action taken to review, investigate and reflect on incidents.

Systems to assess and improve the quality and safety of the service were inadequate. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● We found staffing arrangements were not sufficient to meet people's needs safely.

● The registered manager told us there was no formal staffing assessment in place and a dependency tool was not used to identify what staffing was needed to meet people's need safely both during the day and at night.

● We saw staff were often rushed in their duties. When not carrying out their duties staff were observed to be outside the building, having frequent smoking breaks. The registered manager was unable to provide a staffing rota to demonstrate how effective staffing levels were planned and maintained.

● Two people told us they were lonely. Another person said they had little staff interaction and said, "I never really see them."

The failure to have sufficient staff to meet people's needs safely was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We observed staff not wearing personal protective equipment (PPE) correctly and shared this with the registered manager who then reminded them. Despite reminders, staff continued not to wear PPE correctly throughout the inspection.
● Staff were not aware of donning and doffing processes and informed the inspector they could put their used PPE in an open kitchen bin. This is contrary to good infection control guidance.
● There were insufficient facilities for handwashing in the service. The ground floor bathroom used by people had no paper towels or hand drying facilities. The top floor bathroom used by people had no soap or paper towels.This meant that staff, people and visitors could not wash their hands properly.
● There was not a robust process for signing in visitors and checking their temperature or the result of a lateral flow device test before entering the premises.
● Care staff completed cleaning in the service and there was a schedule for this. However, the schedule did not include frequent touch points and at no point did we observe light switches, doors, bannisters etc being cleaned during our visit.

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

● We were somewhat assured that the provider was accessing testing for people using the service and staff.

● We were somewhat assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were not assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Visiting in care homes
● During our inspection visit we observed relatives were able to visit their loved ones in accordance with current 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. We found the service did not have effective measures in place to make sure this requirement was being met.
● During the inspection we were not asked for evidence of COVID-19 vaccination, and professionals visiting were not all asked for evidence of their vaccination status.

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.

This is the first inspection for this newly registered service. This key question has been rated 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.

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

- Systems and processes to assess, monitor and improve the quality and the safety of the service were either not in place or lacking in robustness. For example, medicines audits carried out by the registered manager failed to identify the safety concerns we identified during our visit.
- Throughout the inspection we saw the registered manager interact in a friendly way with people who recognised the registered manager and responded well to them. However, we saw very little understanding of regulatory requirements around the safety of the premises and had to intervene by pointing out where people might be exposed to risk.
- Several times during the inspection we had to intervene and signpost the registered manager to best practise guidance including the Health and Safety Executive and National Institute for Clinical Excellence (NICE) guidance.

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

- There was a lack of care planning around how the service was going to support people to rehabilitate from their injuries. There was an absence of information and guidance as to how people would be supported to increase their independence.
- We did not see during our inspection where the service had supported anyone in its care to achieve a positive person-centred outcome.
- People and their belongings were not treated with dignity and respect. For example, clothing was discarded in one of the bathrooms, clutter discarded behind an armchair in the lounge, the communal hoover was stored in one person's bedroom, and some furniture was in poor repair. This meant the culture within the service was not positive and did not recognise the service as being people's home.
- The service did not always promote a person-centred culture that treated everybody equally and with dignity and respect. For example, one care staff member refused to support people with continence needs. This meant people had to wait until another staff member was available. This did not ensure people's dignity was promoted and added to the pressure staff were already under.

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

- People were not involved in a meaningful way in the development of their care and support and information was not provided in a way which met people's individual communication needs.

● Care records did not record what people's wishes were, what their preferences were or how, when and by whom they would like to be supported.
● There was an absence of evidence that consideration had been given about how to best support people with daily tasks such as eating and drinking, continence, personal care and medicines.

Continuous learning and improving care; Working in partnership with others
● There was not a culture of learning, where feedback had been given on issues such as safe management of medicines, we found this had not been acted on.
● Some professionals we spoke with did not feel that the registered manager was always transparent and acted in the best interests of people.

Systems to assess and improve the quality and safety of the service were inadequate. This placed people at risk of harm. This was a 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
● The provider told us they had informed families there was a current safeguarding investigation ongoing within the service.