Vision Home Care Ltd

Vision Rolleston

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Vision Rolleston is a small residential care home. It is registered to support up to four people. At the time of the inspection, two people were using the service. The service mostly supports people with mental health, learning disabilities and physical health.

The service is registered to be at the address 20 Rolleston Street, Leicester, LE5 3SA. However, when we arrived at the inspection, we were informed the service had moved to 1 Greenlawn walk, Leicester, LE4 0BN. This location is not part of the provider's condition of registration. We are therefore considering our next enforcement action for this different location. Our inspection occurred at this 1 Greenlawn walk address, to ensure people were being supported safely.

People's experience of using this service and what we found
People were not protected from the transmission of COVID-19. The service was unclean and government guidance related to COVID-19 was not followed. Environmental risks like fire and legionella were not managed safely. People's care plans did not provide clear guidance to help staff keep people safe. Staff did not receive high quality training, to ensure they had the skills to support people. Medicine administration was not always recorded in a timely way, but were otherwise given safely.

Safe recruitment processes were not in place, to ensure staff were of good character and suitable skilled to work at the service. There was often only one staff member at the service, this was not always enough staff to meet both people's needs.

Incidents that occurred at the service were not always well managed. The provider's oversight of these incidents was poor quality, this effected the ability to learn lessons when things went wrong.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies at the service guided good practice, but were not followed effectively.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. The provider was not registered to support people with learning disability needs, but we found that both people at the service had these needs. The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture:

Right support: The model of care did not maximise people's choice, control and independence. People were

not involved with creating their care plan and were not happy with the type of care provided to them. The care did not always maximise people's independence.

Right care: Care was not person centred. Staff did not always ensure people received suitable and timely support from external health and social care professionals. Restrictive practices were used and these did not promote people's dignity and human rights. Incident records showed staff were not always skilled to support people's care needs.

Right culture: The service did not have a good ethos. People described that decisions were made "at the last minute" and they were not always involved with changes made to 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
This service was registered with us on 4 March 2019 and this is the first inspection.

Why we inspected
We received concerns about the safety of infection control processes during the COVID-19 pandemic. The inspection was therefore targeted to look specifically at infection control processes. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements

When we inspected, we found concerns with the restrictions imposed on people's freedom. We therefore widened the scope of the inspection to become a focused inspection. This included the key questions of safe, effective and well-led.

We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

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

We have identified breaches in relation to regulation 12 (Safe care and treatment), regulation 19 (fit and proper persons deployed), Regulation 11 (Consent) and regulation 17 (Good Governance)

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 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.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration,

we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Vision Rolleston

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 included checking the provider was meeting COVID-19 vaccination requirements. 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 two inspectors

Service and service type
Vision Rolleston 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.

Notice of inspection
The first day of the inspection was unannounced. We gave the service 24 hours' notice of the second inspection visit. This was because the service is small and on the first visit people were out for the day. We wanted to be sure there would be people at home to speak with us.

What we did before the inspection
We sought feedback from the local authority who work with the service. 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 gave the provider the opportunity to tell us about the service during the inspection.

During the inspection
We spoke with both people who used the service about their experiences of the care provided. We spoke with one member of care staff, and the registered manager/ provider (they were the same person and legally accountable for how the service is managed). We also spoke with three external professionals who had worked with the service.

We reviewed a range of records. This included the care records related to two people who used the service. We considered a variety of records relating to the management of the service, including policies and procedures.

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 as inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

- We were not assured that the provider was preventing visitors from catching and spreading infections. We were not assured the provider was facilitating visits for people living in the home in accordance with the current guidance. Staff did not always check visitors COVID-19 test status when they arrived.
- 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 identified a breach of Regulation 12(3), as some staff were not fully vaccinated. We also found staff did not always check that other visiting professionals were suitably vaccinated against COVID-19. The Government has announced its intention to change the legal requirement for vaccination in care homes.
- We were not assured that the provider was meeting shielding and social distancing rules. The property was small, and this would make social distancing difficult. This had not been considered in a risk assessment or business continuity plan.
- We were not assured that the provider was admitting people safely to the service. There was no policy to guide staff on how to admit new people safely to the service.
- We were not assured that the provider was using personal protective equipment (PPE) effectively and safely. Both the registered manager and a staff member were repeatedly seen with their face mask on incorrectly. Not wearing face masks appropriately put's people at risk of COVID-19 transmission.
- We were not assured that the provider was following current government guidance, to ensure appropriate COVID-19 testing for staff and people using the service.
- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. The service was visibly dirty and these dirty areas were not covered in the cleaning schedules to ensure they would be cleaned effectively in the future.
- We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed. The provider had not completed a site risk assessment to consider how they would manage in the event of an outbreak. The provider responded by completing a risk assessment, but it remained poor quality as it did not follow current government guidance
- We were not assured that the provider's infection prevention and control policy was up to date. We expressed concern about this and limited improvements were made.

Assessing risk, safety monitoring and management

- Risks related to legionnaires disease were not safely managed at the service. If water sources are not managed safely, legionella bacteria can develop. If swallowed, this legionella bacteria can put people at serious risk of ill health from legionnaire disease. The provider had not completed the required checks to

ensure the water people was using was safe. We saw limescale on multiple taps. The development of limescale can be a potential feeding source for legionella bacteria and increase the risk of bacteria development and transmission. This limescale was not covered in the cleaning checks at the service- therefore increasing the risk of legionella bacteria development.

● The provider's fire risk assessment was not accurate. For example, it did not correctly describe the distance from bedrooms to leave the building in the event of a fire. This puts people at risk of harm if an emergency evacuation was needed.

● People's health care needs were not clearly described in their care plans. This put them at risk of receiving unsafe care. Staff were guided to complete health checks on one person. However, there was not enough guidance on how to do this correctly, or when to call for medical support. The records showed the person was unwell and required a medical review. Staff had not arranged this in a timely way.

Learning lessons when things go wrong

● Incidents were not managed safely at the service. Staff used poor language to describe incidents. For example, an incident report described a person's behaviour as 'they did it to annoy me'. The person has mental health needs, and the registered manager described that their behaviour is unintentional. The use of this language is therefore not appropriate for staff to use and shows a lack of understanding of the person's mental health needs.

● Incidents were not analysed effectively to ensure that improvements were made in future. For example, incident form analysis stated 'It's just one of their behaviours'. The incident should have been analysed to see what triggered this behaviour to occur, and what staff could do differently in the future to keep the person safe. The poor analysis of incidents; prevented lessons being learnt.

We found people were not always provided with safe care and treatment. Poor infection control processes put people at risk of COVID-19 transmission, risks were not safely assessed, and lessons were not learnt when things went wrong. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● We looked at four staff recruitment files, none of these staff were recruited safely in line with legal requirements. Our concerns included, missing or unsuitable references from previous employers, large unexplained gaps in staff employment/training history and missing identification checks to ensure the staff member was who they said they were and legally able to work. These safe recruitment checks were required to ensure staff were suitable, safe and of good character to work with the people at Vision Rolleston.

● We identified that one staff member had not had a disclosure and barring check before starting to work with people at the service. 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.

Poor quality recruitment meant we were not assured that staff were safe to support people. This was a breach of regulation 19 (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● We identified that there was often only one staff member available at the service. One person required one staff member at all times, so the other person was unable to access staff support. This amount of staff was not sufficient staffing to meet both people's needs at the service.

Systems and processes to safeguard people from the risk of abuse

● Staff had received training on how to report signs of abuse.
● We were concerned that one person had experienced theft. The registered manager had not reported this theft to the police. The failure to notify the police of theft, puts the person at risk of the crime against them not being suitably investigated.

Using medicines safely
● Medicines were not always recorded in a timely way when they were given to a person. This poor recording risks staff not knowing what medicine a person has had in the event of an emergency.
● Medicine was otherwise recorded as being given in line with prescription requirements.
● Medicine was stored in a suitable safe place.
● Nobody received 'as needed' medicines, so we could not assess the safety of practices related to this type of medicine.

Inadequate

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 available evidence.

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 people's care, support and outcomes.

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 and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- The service was not following the principles of the MCA. One person was subject to multiple restrictions on their daily routines. Including; not having free access to toilet paper, clothing, toiletries, room furnishings or the television remote control. The provider had completed a mental capacity assessment, showing the person could make day to day decisions. They had not completed any assessments into the person's ability to make decisions on these specific areas.
- We expressed concern about these restrictions in a letter to the registered manager. The provider responded that they had completed a capacity assessment into the person's ability to make decisions about their clothing. They had assessed that the person was able to make decisions about their clothes. However, the registered manager had continued to guide staff to restrict the person access. This decision was not in line with the principles of the mental capacity act, and did not respect the person's human rights. The registered manager had again failed to assess the person's ability to make decisions into other areas that they experienced restrictions on.
- Restrictions related to this person, also impacted the daily freedoms and routines of the other person using the service. The impact of this, had not been considered by the registered manager.
- The registered manager had completed a deprivation of liberty referral for one person at the service. However, this was not completed accurately. This poor-quality referral would impact the Local Authority's ability to assess the restrictions imposed on the person.

The service did not comply with principles of the Mental Capacity Act. This was a breach of regulation 11 (consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Care plans did not holistically assess people's needs. This would impact the ability to provide effective care. For example, people's sexuality had not been considered to ensure that effective care was provided in this area.

● Daily records did not accurately reflect the care that was provided to people. For example, on the first day of the inspection, neither of the people were in the care home. However, when we returned to the service on our second visit, daily notes had been written and described that both people were in the building all day. We were also informed that the service had moved location, however there was no evidence on daily notes that people had moved house. This poor recording, makes it difficult for the service and external professionals to understand people's routines, abilities and how best to support these people.

Staff support: induction, training, skills and experience

● Staff were not always provided with good quality training. For example, the content of infection control training did not reflect current government guidance for personal protective equipment (PPE) use. We also saw staff did not use PPE effectively and in line with current government guidance.

● Staff had received training in how to support people's mental health needs. However, records kept by staff, suggested a poor ability to manage behaviour that challenged them.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Staff did not effectively work with other agencies to provide effective care. Staff recorded one service user's physical health observations each day. When we read the records, we were concerned about the person being unwell, so spoke to the person's GP. Their GP was equally concerned about the symptoms displayed and invited the person to the GP surgery for a medicine review. Staff had not worked effectively with health services to ensure a timely review of the person's health needs.

● One person was subjected to multiple restrictions on their daily routines (see 'Ensuring consent to care and treatment in line with law and guidance' section). We approached the health and social care professionals involved with the person. They confirmed that they had not been approached about these restrictive practices or how to support the person in the most effective way.

Adapting service, design, decoration to meet people's needs

● The provider had recently moved the people into a new building. This building had not yet been assessed by our registration team to ensure it was suitably adapted to meet people's needs.

Supporting people to eat and drink enough to maintain a balanced diet

● We saw both people were supported to eat and drink enough food.

● We observed the food provided to people was healthy and a balanced diet.

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.

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

- The service did not promote good outcomes for people. The care provided was overly restrictive and did not considered the ability of a person to make their own decisions. This did not empower people to live to their fullest potential.
- Staff did not have sufficient guidance in care plans, to understand how to support people in the best way. Care plans had not been reviewed regularly, and where they were reviewed review was not effective to ensure improvements were made.
- The service policies were poor quality and did not reflect current guidance. For example, they referred to legislation that had been replaced. This meant staff were not guided to follow current standards.
- The mental capacity policy was good quality, however the registered manager had not followed it by completing mental capacity assessments when needed.

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 did not effectively review incident records to identify when things went wrong. We expressed concerns about this and asked the registered manager to review the incident records again. The review completed was poor quality and not effective.
- The registered manager did not effectively review daily records kept by staff, to ensure that records were accurate.
- Due to the registered manager's poor oversight, they had not identified concerns at the service. This would impact their ability to improve the quality of care provided.

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

- The registered manager was not always clear about their role. They had moved people to a new location, without having completed the required environmental safety risk assessments, for example fire and legionella checks. This poor oversight put people at risk of moving to an unsafe environment.
- After our inspection, we explained our concerns to the registered manager. The registered manager completed an action plan and provided additional evidence of changes they made after the inspection. However, we found the action plan and evidence was poor quality and did not assure us that sufficient improvements would be made.

Continuous learning and improving care

● There was limited evidence of auditing at the service. Where audits had occurred, they had not identified shortfalls to ensure required improvements being made to the quality of care.

● We expressed concerns about the quality of care provided. The provider provided us with an action plan, however this was poor quality and did not give us enough assurance that all improvements would be made.

Working in partnership with others

● Health and social care professionals told us that they had not always been contacted when people's needs changed. We described people's needs to them after our inspection, they told us that they planned to visit as soon as possible and were concerned that referrals had not been made soon by the registered manager.

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

● There was limited evidence that people were engaged with the running of the service. One person said, "We are told things will change. It's all last minute. But that's the registered manager."

● Staff had one to one supervision meetings with the registered manager, to reflect on their work. However, we were only shown evidence that this had occurred once for each staff member.

The service was not well managed. The provider had not ensured that the service was following current standards. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed Poor quality recruitment meant we were not assured that staff were safe to support people. This was a breach of regulation 19 (fit and proper persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 11 HSCA RA Regulations 2014 Need for consent The service did not comply with principles of the Mental Capacity Act. This was a breach of regulation 11 (consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We added conditions onto the provider's registration. This requires them to make changes to the service. It also restricts them admitting new service user's without our permission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found people were not always provided with safe care and treatment. Poor infection control processes put people at risk of COVID-19 transmission, risks were not safely assessed, and lessons were not learnt when things went wrong. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We added conditions onto the provider's registration. This requires them to make changes to the service. It also restricts them admitting new service user's without our permission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service was not well managed. The provider had not ensured that the service was following current standards. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We sent the provider a warning notice. Requiring them to improve their oversight at the service