S.E.L.F. (North East) Limited

S E L F Limited - 15 Park View

Inspection report

15 Park View
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Tyne and Wear
DH5 9JH

Tel: 01915208570

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02 September 2021
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04 October 2021
08 October 2021

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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
S E L F Limited - 15 Park View is a care home and provides accommodation and support for up to eight people living with a learning disability. There were eight people living at the service when we visited.

People's experience of using this service and what we found
Risks to people were not always safely managed, monitored or assessed. The service did not have effective systems to protect people from the risk of financial abuse. COVID-19 protocols were not always followed, and the service did not have effective systems to prevent and control the spread of infections.

We found restrictions had been placed on people including holding people's cash cards, allocated time slots for smoking and vaping and fixed timings for mealtimes and administration of medicines. The provider took immediate action to support people's fundamental human rights in line with legislation when we brought this to their attention.

Quality assurance systems were not effective, lacked detail and did not include all aspects of the service. The issues we found during the inspection had not been recognised. Some of the managerial duties had been delegated to another manager. The registered manager and provider had not maintained an oversight of the service, which facilitated a poor culture and allowed poor and unlawful practices to be established and embedded.

The service did not ensure enough staff were deployed to meet people's needs. Staffing rotas did not always reflect the number of staff on duty and the provider's expected staffing levels were not achieved.

Record keeping was poor. Maintenance, infection control and people's clinical records were not always completed, and audits failed to identify this.

People's confidential records were not always accurate and complete and were not held securely.

A training programme was in place. Staff received supervisions and appraisals. However, the majority of staff told us that they were not free to discuss issues at their supervisions as it resulted in a negative impact on them or the rest of the staff team.

Medicines were managed safely. People were referred to health professionals when required.

People gave mixed feedback about the service. Some people told us they were happy whilst others expressed their dissatisfaction about the restrictions placed upon them.

Social work professionals we spoke with were positive about the service and told us people were happy and settled.

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 and systems in the service did not support this practice

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.

Based on our review of the key questions of safe, effective and well-led the service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support: Restrictive, controlling practices had been adopted within the service. Peoples' choices had been removed in certain aspects of their lives.
Right care: People did not receive person-centred care and support and the service did not promote people's dignity, and human rights.
Right culture: Attitudes and behaviours of the management team did not ensure people using services lead confident, inclusive and empowered lives.

Care staff were compassionate about ensuring people lived full lives. They recognised the issues at the service and repeatedly raised concerns with the management team.

The provider is conducting a full investigation into the failings and has put actions in place to address restrictions immediately.

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 20 May 2019).

Why we inspected
The inspection was prompted in part due to concerns received about the safety of people using the service, staffing levels and management of the service. A decision was made for us to inspect and examine those risks.

An initial inspection took place on 2 September 2021 to establish that people were safe. We inspected and found there was a concern with staffing levels and the management of the service, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe, effective and well-led.

This report only covers our findings in relation to the key questions safe, effective and well-led as we were mindful of the impact and added pressures of COVID-19 pandemic on the service.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe, effective 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.

Following the inspection, the provider has taken action to mitigate the risks. The provider was receptive to our feedback and has implemented new systems and procedures in response.

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.

We have identified breaches in relation to safe care and treatment, safeguarding, dignity and respect, staffing and good governance at this inspection.

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

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 have arranged to 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

S E L F Limited - 15 Park View

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
This inspection was carried out by three inspectors.

Service and service type
S E L F Limited - 15 Park View 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
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. 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. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service about their experience of the care provided. We spoke with members of staff including the registered manager, deputy manager, 13 support workers and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with three social care professionals who regularly visit the service.

We reviewed a range of records. This included two people's care records and medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance records, and care plans.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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

● People were not protected from the risk of financial abuse. Discrepancies were found with people's financial records and the registered manager was unable to locate peoples' financial records dated before July 2021. We raised our concerns with the police and an investigation is ongoing.

The service failed to have effective systems to prevent discrimination against service users on grounds of any protected characteristics (as defined in Section 4 of the Equality Act 2010) of the service user. And the service failed to ensure effective systems were in place to protect service users from the risk of financial abuse. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff understood their safeguarding responsibilities. Some staff had whistle-blown to the CQC and their information had prompted the inspection.

Following the inspection, we referred the matter to the local authority safeguarding team and the provider advised us that they are looking into these matters.

Assessing risk, safety monitoring and management

● Risks to people were not managed safely. Action was not taken to manage known risks to people. Care records contained no risk assessments although we noted some people had identifiable risks. We asked the provider to address this matter.

● People's behaviours which may challenge others were not robustly monitored. This made it difficult to identify patterns and triggers and support people with strategies to reduce the incidents from happening.

● Documents relating to fire safety were not maintained. The signing in book was not used, this meant service users and staff safety was compromised in the event of a fire or emergency.

The provider had failed to manage the risks relating to the health, safety and welfare of people. 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

● Staffing rotas did not always reflect the number of staff on duty. The provider's expected staffing levels were not achieved. This meant at times not enough staff were deployed to support people safely.

● People and staff told us there was a lack of staff to meet peoples' needs. Not enough staff were available to support people on activities in the community.

● Some people were allocated additional 1:1 support by their local authority. Staff and people told us this was not happening, and daily diaries did not record any 1:1 activity.

Although we found no evidence that people had been harmed, the provider had failed to ensure enough staff were deployed to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the provider advised us that they were investigating the discrepancies in the staffing rotas.

● Staff were recruited safely, and appropriate pre-employment checks were carried out.

Preventing and controlling infection
● The service did not always follow COVID-19 protocols. Visitors entering the service did not always have their temperature checked or were asked COVID-19 screening questions.
● PPE was not readily available around the service. On entering the service no PPE was available which meant visitors who did not have PPE had to walk through the service to the manager's office to obtain a facemask.
● Records relating to temperature checks and cleaning were not completed. Records showed on one day only one staff member was recorded as having a temperature check. The registered manager said the checks and cleaning were taking place and it was poor record keeping.
● The Service did not have a system for recording staff members Lateral Flow Device tests. This meant the service did not have an accurate record of COVID-19 testing.

Although we found no evidence that people had been harmed, the service did not have effective systems to prevent and control the spread of infections. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us a visit by the local Infection Protection and Control (IPC) Nurse had been arranged prior to our inspection.

Learning lessons when things go wrong
● The service did not have effective systems to learn when things went wrong and this meant that opportunities for prevention of further occurrence were missed. However, the provider was open and receptive to our inspection feedback and made changes in response.
● Accidents and incidents were not always recorded and investigated. A review was not conducted to learn from trends or patterns of incidents.

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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 Act 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.

● Elements of the home were institutionalised and peoples' fundamental human rights and choices had been removed. People and staff told us about restrictions which were placed on people including holding people's cash cards, allocated time slots for smoking and vaping and fixed timings for mealtimes and administration of medicines.

The service failed to have effective systems to prevent discrimination against service users on grounds of any protected characteristics (as defined in Section 4 of the Equality Act 2010) of the service user. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they wished to go to the theatre. They said the manager had told them trips could not take place due to COVID-19 restrictions, which did not reflect government guidance at the time.
● The management team were instrumental in the restrictive practices. We discussed the issue with the management team, and they confirmed such restrictions were in place and failed to understand how this was unlawful and infringed peoples, human rights. Staff told us they had raised their concerns about these practices with the manager, but nothing changed. Some staff had whistle-blown to the CQC and their

information prompted the inspection.

Following the inspection, we referred the matter to the local authority safeguarding team and the provider stopped all the unlawful restrictions we found.

The service failed to ensure people's personal preferences, lifestyle and care choices were met. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This also contravenes Article 8 of the Human Rights Act - respect for your private and family life.

● Staff were observed supporting and encouraging people throughout the inspection to make day to day decisions and choices.

Supporting people to eat and drink enough to maintain a balanced diet
● People did not always have choice when they could take their meals. Meal choices were discussed at a service user meeting which included all of the provider's three homes.
● Care plans did not record people's meal preferences or how and when they wished to take their meals and did not outline any activity involving being part of the preparation of meals.

Adapting service, design, decoration to meet people's needs
● The maintenance of the home was not well managed. Damage throughout the home including people's rooms had not always been recorded and therefore had not been repaired.
● People decorated their rooms as they wished. One person proudly showed us their room which was personalised and homely.

Supporting people to live healthier lives, access healthcare services and support; Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Pre-assessments took place prior to people moving to the service to ensure their needs could be met.The initial assessment was detailed however this information was not used to develop peoples' care plans. Some failed to transfer important information relevant to support people safely.
● People's care plans contained little detail and did not describe people's preference in the way they wished to be supported which meant that the service culture did not uphold and protect the individual rights and needs of people who could not advocate for themselves.

Staff support: induction, training, skills and experience
● The service had a three-year training programme. The registered manager had started to organise refresher training.
● New members of staff completed an induction and a period of working with experienced staff.
● Staff had supervisions and appraisals. The majority of staff told us they did not feel supported by the management team and if they raised concerns or challenged situations, they alleged they were adversely treated.

Following the inspection, we asked the provider to investigate the allegations.

Staff working with other agencies to provide consistent, effective, timely care
● The service had systems and procedures in place to refer people to other professionals when required. People were supported to access the GP, and district nurses.
● Health and social care professionals told us the staff team had worked with people and achieved positive

outcomes, describing people as being very settled and happy in their placements.

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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;

- Quality assurance within the service was not effective. Audits had failed to identify the issues found during this inspection regarding risk, financial abuse, care records, infection control issues and management of the service.
- The registered manager failed to have any oversight of the home. The registered manager had delegated some managerial duties to another manager. However, they did not monitor and assess the manager in that role.
- Record keeping throughout the service was poor. Records relating to maintenance of the building, infection control and, accidents and incidents were not complete and accurate. Audits did not identify these failings.
- Confidential records were not always held securely.

The service failed to have effective systems to assess, monitor and improve the quality and safety of the services. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff spoke positively about their roles. They were passionate about ensuring people received great care and support. Staff worked extended hours to ensure people were safe. They recognised the failings in the service and repeatedly tried to address this with the management team. Some staff had whistle-blown to the CQC and their information prompted the inspection.

- The service did not promote a positive and open culture. During discussions with people and staff they described a controlling and restrictive atmosphere at the service which did not uphold their fundamental human rights. Morale amongst staff was low. Staff told us they were not listened too when expressing their views.
- The service was not person centred. People had unlawful restrictions and controls placed upon them. Whilst staff questioned such actions with the management team, they were told to maintain the culture which did not support or empower people in the way that the legislate demands to uphold their rights an autonomy as individuals.
- Staff did not feel valued and respected. Staff expressed concerns to us and especially about the lack of opportunities and support for people to develop.

Following the inspection, we asked the provider to review the culture and practice in the home in line with the regulatory expectations and the right support, right care, right culture guidance.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; working in partnership with others

● The service regularly sought feedback from staff, people, and relatives. Feedback reviewed was positive from all. However, during our inspection, staff and people we spoke with expressed concerns about the management of the service as detailed above which meant that the feedback system being deployed was not effective or representative of what was actually felt about the service provision .

Following the inspection, the provider advised they were looking into the concerns raised.

Continuous learning and improving care

● In line with all of the findings above it was strongly evident the service did not have effective systems to reflect and analyse information to drive improvement. Important information was not always escalated to the provider by the management team.

Following the inspection in light of the widespread and significant failings we asked the provider to address these issues urgently. We also shared our findings with the local authorities who had people placed at the service.

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 10 HSCA RA Regulations 2014 Dignity and respect The service failed to ensure people's personal preferences, lifestyle and care choices were met. Regulation 10(1)

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 manage the risks relating to the health, safety and welfare of people. The service did not have effective systems to prevent and control the spread of infections Regulation 12 (2)(a), Regulation (2)(h)

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 service failed to ensure effective systems were in place to protect service users from the risk of financial abuse. The service failed to have effective systems to prevent discrimination against service users on grounds of any protected characteristics (as defined in Section 4 of the Equality Act 2010) of the service user. Regulation 13(1), 13(4)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure enough staff were deployed to meet people's needs. Regulation 18(1)

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 17 HSCA RA Regulations 2014 Good governance The service failed to assess, monitor and improve the quality and safety of the home. . Regulation 17(2)(a)

The enforcement action we took:

warning notice issued