CareTech Community Services Limited

CareTech Community Services Limited - 68 West Park Road

Inspection report

68 West Park Road
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Birmingham
West Midlands
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
68 West Park Road is a residential care home providing personal and nursing care for up to 14 people. The service provides support to people with learning disabilities and autism. At the time of our inspection there were 13 people using the service. Each person had their own flat within the home including a living room, bedroom, and bathroom. All but one person had their own kitchen. People had access to a shared lounge area and a shared kitchen. They also had access to a shared garden.

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.

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

Right support
Systems had not always highlighted health and safety risks within the home. When health and safety concerns were identified, they were not always addressed in a timely way. Recording of incidents was not always detailed and records had not always been checked by management. This meant a safeguarding concern had been missed but was investigated when we highlighted it.

Right Care
People's care records were not always up to date regarding the possible need for the use of restrictive practice as a last resort. This led to confusion amongst staff. Although staff could tell us about some people's wishes and plans, it was not easy to see how their long-term goals and aspirations were being met.

Right Culture
Staff did not always receive regular supervision, which meant some opportunities to identify gaps in their knowledge could be missed. Agency staff were not given the same training in restrictive practices as the established staff team. This could create a risk of confusion about appropriate practice amongst the staff team.

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

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 January 2022).

Why we inspected
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 received concerns in relation to the management of health and safety risks and recording and monitoring of incidents in the home. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

During the inspection the provider took steps to address many of the concerns we raised. All the immediate health and safety risks which had been identified in the home had been addressed shortly after the completion of our inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 68 West Park Road on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to ineffective systems to protect people from possible harm, poor maintenance of equipment designed to keep people safe and failings in the oversight and quality assurance systems in the home 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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

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Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was completed by an Inspector and an Assistant Inspector.

Service and service type
68 West Park Road 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. 68 West Park Rd 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we had received about the service. We sought feedback from the local authority and professionals 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 communicated with 11 people who were living at 68 West Park Road about their experience and views of the service. People who were unable to talk to us used different ways of communicating including British Sign Language, pictures, and symbols, writing on a board and their body language. We spoke with 6 relatives about their experience of care provided. We spoke with 10 staff including, the registered manager and deputy manager, regional managers, team leads, the resourcing business partner, and day and night support workers. We reviewed a range of records. These included 5 people's care records and multiple medication records. We looked at 2 staff files in relation to recruitment and staff supervision. We reviewed a variety of records relating to the management of the service, including policies and procedures. We also contacted 2 professionals who work regularly with the service.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- Systems and processes were in place to support staff to protect people from abuse. However, some processes were not being followed correctly. This had led to failures in monitoring for risk of abuse.
- We saw failure to report some bruising on a person to a team lead or manager had resulted in a failure to investigate the concern. The concern had also not been shared with the local safeguarding team for further investigation. This meant there had been no attempts to identify the cause or consider any possible ongoing risks to the person.
- We saw the process to report an incident had not been followed correctly. Recording of an event lacked details. The management team had not fully investigated the incident to ensure the person had received safe and appropriate support.
- Staff were clear restrictive practice should be used as a last resort. However, there was confusion amongst the staff about who may need restrictive practice to keep them safe. Care records had not always been updated to reflect the most recent guidance for staff. This left people at risk of inappropriate use of restrictive practice.
- During the inspection many staff were attending training to support the safe use of restrictive practices. However, agency staff were not provided with the same training and not all staff had completed any of the training, including an e-learning introduction to the subject. Amongst staff we spoke with there was some confusion about the terminology used in the care records about restrictive practice. This meant there was a risk of staff using restrictive practice inappropriately or being unable to recognise what inappropriate restrictive practice was.

Systems and processes to safeguard people from the risk of inappropriate restrictive practice were not effective. This put people at risk of harm from inappropriate restrictive practice. This was a breach of regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When the failure to investigate the unexplained bruising was highlighted to the management team, appropriate steps were taken to investigate and report this concern.

Assessing risk, safety monitoring and management

- Fire safety equipment had not been properly maintained and in some cases was not suitable for the purpose it was being used for. All the fire doors in the home were no longer fit for purpose and needed replacement.
- Mechanisms to ensure doors closed in the event of a fire were not all functioning and needed batteries replacing. We saw staff using paper to wedge open a door which did not have a functioning mechanism.

This meant the door could not automatically close in the event of a fire, creating a risk of a possible fire spreading more rapidly.
● A fault had been identified with the fire alarm panel in January 2023. The panel did not correspond with the number on people's doors. This meant in the event of a fire only a zone could be identified, which was either 3- or 4-people's flats. At the time of our visit the panel had still not been repaired. This meant there could be a delay in locating the source of a fire as the fire alarm panel could not clearly show where the fire was. The inspector contacted West Midlands Fire Service to ensure the situation was assessed and assist the service to consider any risk mitigation whilst awaiting repair of the fire panel.
● A considerable amount of combustible material, much of it in need of disposal, had been stored in the cellar. There was a hole in the boiler room wall, which would allow fire to spread. These issues posed a fire hazard to people.

Systems to monitor and mitigate risks to people's health, safety and welfare had failed to ensure fire safety equipment was fit for purpose. This placed people at risk of harm in the event of a fire. This was a breach of regulation 15(1) (c) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection a programme to replace all the fire doors was underway. The provider took action to ensure all mechanisms to close doors in the event of a fire had their batteries replaced and were in working order during our visit. By the end of the inspection the combustible materials in the cellar had been cleared.

● Staff had not all participated in fire drills at the time of our inspection. They had also not received training in the use of fire evacuation equipment. Staff were not always signing people in and out of the building in the fire register. This meant people were at risk of a delayed emergency response in the event of a fire.
● We saw the recording of health-related events such as epileptic seizures was not always robust. Some records were not clear about whether a person had been injured as a result of a seizure. Records had not always been checked and signed by a team lead or manager which was the providers expected process. This meant management could not always monitor risks and identify trends associated with people's epileptic seizures. This could lead to missed learning opportunities to improve outcomes for people experiencing seizures.
● We saw in one incident record there was no evidence staff had ensured a person who was injured had had medical attention. There was no clear guidance for staff in this instance on what level of medical attention may be required. This put people at risk of an ineffective response when sustaining an injury.

Systems to assess, monitor and mitigate risks to the health, safety and welfare of people using the service had failed to identify risks to people's safety. This placed people at risk of harm. This was a breach of regulation 12(2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Although systems were in place to enable the staff team to learn from incidents and accidents, they had not always been used effectively enough to promote learning.
● Incident forms were not always completed fully or in enough detail to enable effective analysis.
● Incidents were not always escalated appropriately and were not always subject to robust analysis.

Staffing and recruitment
● People were supported by adequate numbers of staff, although the service depended on regular agency staff use. Staff told us efforts were always made to cover all the shifts needed. However, training and support for agency staff was not robust.
● Members of the permanent staff team had to complete training accredited by the Restraint Reduction

Network training standards. However, agency staff supporting the same people were not provided with the same accredited training. Agency staff also received little or no formal supervision. This meant the management team could not be assured of the quality and safety of support agency staff would be able to provide.

● Induction for most staff had not included participation in a fire drill. This meant the induction training process did not always promote safety by ensuring staff knew how to respond to a fire emergency.

●Recruitment checks were made to ensure potential staff were safe and suitable for the role of carer. These included Disclosure and Barring Service (DBS) checks. These provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely

● We noted a couple of concerns with medicines management, but overall people were supported safely and appropriately to take their medicines.

● We saw a person who was supported to use a prescribed cream, did not have a body map to record where the cream should be applied. For new or agency staff this posed a risk of applying the cream incorrectly. We spoke to the management team about this and were told a body map would and should be used.

● We noted a rescue medicine to enable people to come out of a prolonged epileptic seizure, was locked away in 2-3 cupboards (depending on whether the team lead was carrying the keys or had locked them in a third cupboard). The management team had not considered how effective this medicine would be if administration was delayed by how long it took to obtain it. The regional manager assured us this would be reviewed.

● People had personalised care records guiding staff as to how they wanted to be supported with their medicines.

● The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both). They ensured people's medicines were reviewed by prescribers in line with these principles.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● Confusion amongst staff and in care record guidance meant there was a risk of inappropriate use of restrictive practice. Best interest decisions for people regarding the use of restrictive practice needed to be reviewed and updated in some cases.

● Mental capacity assessments had been completed for people and DoLs had been applied for as needed. Staff understood the basic principles of MCA and what this meant for people in relation to their ability to make decisions for themselves.

● Any conditions related to DoLS authorisations were being met.

Preventing and controlling infection

● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. We noted during our visit areas of the shared lounge were dusty and in need of cleaning. There were also some areas of the home particularly in hallways where walls were damaged and could not be easily cleaned. The management team told us requests had been made to complete the repairs.
● 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 using PPE effectively and safely.
● 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
People were supported to receive visitors at 68 West Park Road in line with government guidance.

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. At this inspection 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

- Systems to monitor the safety of the environment had not always enabled staff to identify health and safety risks. Regular checks of the home had not identified the fire hazard caused by the large amount of combustible items stored in the cellar. Systems had not identified the deterioration in the condition of the fire doors until none of them were functioning and all needed to be replaced.
- In some cases, systems had identified issues, but the management team and provider had not ensured they were addressed in a timely way. The fire alarm panel failing to coordinate with the numbers on people's individual flats had not been addressed in a timely way. The management team had not identified the need to risk assess the impact on a possible fire emergency whilst awaiting a repair to the fire alarm panel.
- Although the registered manager considered some guidance in care records regarding restrictive practice was no longer correct, steps had not been taken to update the guidance. This had contributed to confusion amongst the staff team regarding who may need to be supported with restrictive practice. This left people at risk of inappropriate restrictive practice.
- Quality assurance checks had not identified some staff were not following processes to ensure incidents could be monitored and analysed effectively. This had resulted in a failure to raise a safeguarding concern in a timely way. This had also meant there was not always clear recording of incidents or checks made by team leaders or management to ensure the quality of information recorded.
- A system to ensure staff received adequate supervision had failed to enable the management team to identify and act on the fact that some staff had not received formal supervision for over a year. This meant staff had not always had a formal opportunity to share concerns or identify gaps in their knowledge, leaving them at risk of providing inappropriate care.

Systems had not always enabled the management team to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took steps to address many of the concerns we identified during and shortly after our inspection. For example, shortly after the inspection the issue with the fire panel was addressed to enable the panel to identify the correct flat number in the event of a fire.

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

outcomes for people
● Systems to monitor supervision provided to staff had not enabled the management team to ensure staff received regular supervision. In one case we saw a staff member had not had supervision since 2019. This meant opportunities to reflect on practice, identify gaps in knowledge and training needs were sometimes missed.
● Some of the management team told us the system to monitor e-learning was not always easy to use. They advised it was not always clear which staff had completed courses. The registered manager advised they had to sometimes rely on staff to report to them if they had difficulty logging on to the system. This meant it was difficult for the management team to ensure all staff had completed training in a timely way.
● Quality assurance checks had failed to enable the management team to identify the confusion amongst staff regarding the use of restrictive practices. Although some staff knew people well and understood their likes and dislikes, there was confusion about whether some people may need to be supported with restrictive practices. Checks on care records had not always identified the need to update them. They therefore did not always reflect changes the management team told us needed to be made in the guidance on who may require restrictive practices as a last resort.
● Quality assurance checks had not enabled the management team to identify the lack of clear future goals and aspirations recorded for people in some cases. Care records did not always demonstrate people's learning and development, goals or long-term aspirations. Staff were able in some cases to tell us about people's plans or goals, but this was not easy to see from people's care records. This meant records could not always clearly demonstrate people's progress in developing independent living skills and trying out new experiences.
● The management team were visible in the service. Staff told us they felt they could approach the management team if they had concerns.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● We received mixed views from relatives regarding their involvement in reviews of their loved one's care and how much they felt able to contribute to the development of the service. Some relatives told us they had not been asked to participate or give feedback. Others said they did participate in reviews. We spoke with the manager about this who advised they were working to try to engage with all relatives who wanted to be part of planning and development of the service.
● Most relatives told us they felt their loved ones were involved in reviews of their care. People's care records were phrased as if written by them rather than about them. People's care records included details of their cultural and religious preferences and gave guidance to staff about how they wanted to be supported with these needs.
● Staff told us there had been more regular staff meetings recently and they felt they could contribute ideas and concerns about the service in this forum.

Continuous learning and improving care
● Opportunities to learn and improve care had sometimes been missed. Quality checks had not always identified examples of staff not recording incidents properly. Incidents were not always fully investigated as a result. This meant the management team could not always fully analyse incidents to look for learning which could improve positive outcomes for people.
● Staff did not always receive regular supervision. This meant opportunities to identify gaps in knowledge were sometimes lost.
● The management team had not always kept up to date with national policies to inform improvements to the service. The management team were not familiar with the NICE guidelines around oral care. They had therefore not ensured people's oral health was risk assessed and monitored regularly in line with this

guidance.

Working in partnership with others
● Records showed people were supported by a range of health professionals as needed. These included occupational therapists, social workers, and specialist consultants.
● One professional who had been working alongside the staff team told us, "The management is proactive in taking actions when required for example booking a GP appointment or taking part in meetings… communication with [the registered manager] and the rest of the management team has been very good."

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
● A duty of candour incident is where an unintended or unexpected incident occurs which results in the death of a person using the service, severe or moderate physical harm or prolonged psychosocial harm. When there is a duty of candour event the provider must act in an open and transparent way and apologise for the incident.
● The provider understood their duty of candour responsibilities and apologised when mistakes had been made.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems to assess, monitor and mitigate risks to the health, safety and welfare of people using the service had failed to identify risks to people's safety. This placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Systems to monitor and mitigate risks to people's health, safety and welfare had failed to ensure fire safety equipment was fit for purpose. This placed people at risk of harm in the event of a fire.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes to safeguarding people from the risk of inappropriate restraint were not effective. This out people at risk of harm from inappropriate restraint.

The enforcement action we took:

We served a warning notice and asked the provider to evidence how they had made changes to ensure they were complaint with the regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had not always enabled the management team to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm.

The enforcement action we took:

We served a warning notice and asked the provider to evidence how they had made changes to ensure they were complaint with the regulation.