Community Integrated Care

Community Integrated Care (CIC) - 4 Seafarers Walk

Inspection report

4 Seafarers Walk
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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
Community Integrated Care (CIC) - 4 Seafarers Walk is a residential care home providing accommodation and personal care to three people at the time of the inspection. The service supports people living with a learning disability and autism in one adapted building and can support up to 5 people.

People's experience of using this service and what we found
The system and processes in place to prevent the risk of abuse of service users were not always operated effectively. Staff had not taken all reasonable steps to make sure people were not treated in a degrading manner. Staff did not always report incidents in a timely way or ensure unexplained injuries were investigated. Procedures in place to safeguard people from financial abuse had not been consistently followed.

Risks to people had not been consistently reviewed or managed safely. This included risks to people from the premises, environment and equipment. We found no evidence that people had been harmed but people could be at risk of harm if actions to mitigate risks were not followed.

The management of people's medicines was not always safe. The provider has acted on these concerns following the inspection.

We were not assured the provider was doing everything possible to ensure the home was clean and infection prevention and control risks were acted on. We have made a recommendation about this. We were assured the provider was otherwise following current guidance to prevent people catching and/or spreading infection.

There were enough staff on duty to meet people's needs. Due to staff vacancies there was a high use of agency staff, but the same and familiar agency staff were used as much as possible.

The systems and processes in place to monitor and assess the quality and safety of the service had not been effective in driving improvement. The systems had not identified the safety and quality of the service was compromised in a timely way. As a result, there has been a significant decline in the quality of the service identified by the provider and the CQC rating has deteriorated from good to requires improvement.

The provider has acted, and the service is now being managed through an 'enhanced support framework.' This means there will be enhanced involvement from the provider's support services. There will be weekly internal senior management meetings to review and update the continuous improvement action plan.

The culture in the service had not been positive or open and the service had not been consistently well-led. We have made a recommendation about staff engagement to support the development of a more positive culture.

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 safe and well-led key questions the service was able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. People received care and support which aimed to give them maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. The culture and practices in the service were being improved to ensure people always experienced safe care that met the values and standards of this guidance.

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 28 May 2019).

Why we inspected
We received concerns in relation to safeguarding, risk management, staffing, service management and culture. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. 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 Requires Improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe and well-led levant key question sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

The provider has taken action to mitigate the risks and is closely monitoring the progress of their action plan for improvement at the service.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Community Integrated Care (CIC) – 4 Seafarers Walk on our website at www.cqc.org.uk.

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 have identified breaches in relation to risk management, management of medication and governance at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Community Integrated Care (CIC) - 4 Seafarers Walk

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 an inspector and an assistant inspector.

Service and service type
Community Integrated Care (CIC) – 4 Seafarers Walk 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 members of staff including the registered manager, a service leader from another of the provider's services, and two care and support workers. We observed care and support staff with all people who used the service as people were unable to talk to us about their experiences.

We reviewed a range of records. This included people's medication records, health and safety records, incident and accident records and other records relating to the management of the service.

After the inspection
We spoke with three members of care and support staff and the relatives of two people. We looked at two staff files in relation to recruitment and a variety of records relating to the management of the service, including policies and procedures. We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

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

- Although staff we spoke with understood abuse and had completed training in safeguarding adults from abuse, we found they had not always responded appropriately to safeguarding incidents.
- Unexplained injuries were not always reported or investigated. For example, a body map for a person showed staff had identified a 'large graze' on their shoulder. This had not been recorded anywhere else and had not been reported as an incident. This meant the circumstances around the unexplained injury had not been investigated. A staff member told us it would depend on the severity of the injury as to whether they reported this as an incident. However, people can be at risk of harm if unexplained injuries are not reported or investigated to try and establish the cause. Following the inspection the registered manager told us they had acted to address this.
- Staff had not always acted to make sure people were not treated in a degrading manner or responded to incidents of abuse without delay. For example, two recent incidents were reported the day after staff had witnessed these incidents, one of these incidents had been degrading for people and staff had failed to recognise and prevent this. Once safeguarding concerns had been raised with the registered manager, they had been fully investigated.
- A staff member told us they did not feel clear about who to report concerns to because leadership arrangements had not been clarified since the departure of the temporary service leader. We spoke to the regional quality business partner about this who told us they would clarify this with staff. A new service leader was due to join the service on 5 July 2021.
- Where people's finances were managed by staff, a risk assessment was in place. This detailed the requirement for staff and the service leader to complete weekly and monthly finances audits. These checks were in place to safeguard people against the risks of abuse of their finances. However, these checks had not been undertaken since March 2021. A provider audit identified this on 3 June 2021, but the service leader failed to act. An audit took place the day before this inspection to reconcile the finance records and identify any errors or issues. We saw the outcome of these audits which showed people's accounts had been satisfactorily reconciled.

The failure to ensure systems and processes were operated effectively to prevent abuse of service users was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● Risks to people were assessed and plans were in place to mitigate these. However, these had not been reviewed in line with the provider's guidance. This meant they may not be up to date or effective. For example, one person's risk assessment for mobility and falls had not been reviewed since July 2020. However, this person had experienced four falls within the past six months. A failure to review the risk assessment meant the measures in place to reduce the risk of falls for this person had not been reassessed based on these falls to ensure they were effective. This put the person at risk of harm.
● Another person had been prescribed an emergency medicine for epilepsy. Their risk assessment stated following the administration of this medicine a record sheet should be completed. Records showed one administration had not been recorded as required. These records support the safe use of this medicine.
● Risks to people from the environment, premises and equipment had not been consistently managed safely. Weekly and monthly health and safety checks had not been completed since February 2021. Weekly sling checks had not been completed since February 2021. Weekly records of the fire alarm system had not been consistently completed since March 2021. Monthly fire extinguisher checks had not been completed in May 2021. A night-time fire drill had not been conducted every six months in line with the providers policy. A failure to ensure risks associated with the environment had been assessed meant people could be at risk of harm from faulty equipment and unsafe premises.

We found no evidence that people had been harmed however, the failure to assess and do all that is reasonably practicable to mitigate such risks placed people at risk of harm. 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 had put plans in place to improve risk management and this was being monitored for completion.
● Staff we spoke with understood people's risks and how to manage them safely. However, risk assessments that are not detailed or current could pose a risk for staff who were not familiar with the people living at the service.

Using medicines safely
● Medicines were not always managed safely.
● One person was prescribed a topical medicine (applied to the skin). There were guidelines in place to instruct staff on its use, but these were not being adhered to. There were risks of skin damage from this product if the prescriber's instructions were not followed correctly. The provider took immediate action to address this.
● Emollient creams had not been assessed for the risk of fire. The provider took immediate action to update people's records to include this information to ensure the risks associated with this were reduced.
● For one person there were gaps in the recording of medicines administration and there was no explanation for these gaps This meant we could not be assured the person had been administered their medicines as prescribed. The provider has taken action to address this.
● Medicines with legal controls are called 'Controlled drugs' (CD's). A CD to be used when required for one person was not recorded on the person's Medication Administration Record (MAR) as a currently prescribed medicine. This medicine had last been administered in December 2020. It was therefore not clear whether this medicine was for use or disposal. Following the inspection, the provider put in place an interim MAR chart.
● Some medicines are prescribed to be taken 'as required' (PRN). For example, medicines for pain relief or to help people manage anxiety. For these medicines a person-centred plan or protocol should be in place to guide staff on their safe and effective administration. We found these were not available for two medicines for one person.
● Medicines for disposal were kept in a locked cupboard. We found an unlabelled envelope containing an

unidentified tablet awaiting disposal. There was no information to indicate what this tablet was, for whom it was prescribed or why this medicine was awaiting disposal. Care home providers should keep records of medicines waiting for disposal.
● The temperature of the medicine storage had not been taken regularly taken over the past five weeks. In addition, some topical medicines were stored in the bathroom and the temperature of this storage was not monitored. This is important to ensure medicines remain effective.

The failure to ensure the proper and safe management of medicines was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider has acted promptly to make improvements. More time is required to ensure the safe management of medicines is embedded into practice.

Preventing and controlling infection
● We were not assured the provider was promoting safety through the hygiene practices of the premises or that Infection Prevention and Control (IPC) risks were always acted on. During the inspection we observed staff were carrying out cleaning duties and the home appeared clean. A staff member told us that whilst basic cleaning was being carried out some of the more 'heavy duty 'cleaning tasks carried out at night were not always completed to a good standard. We saw the night staff cleaning schedules for the period 01 -22nd June 2021. Some dates were missing and not all the required tasks had been marked as completed.
● An IPC audit was carried out on 06 June 2021. The audit referred to several areas of the home not being clean including people's rooms, kitchen, toilets and bathrooms, and there is no record of an overnight clean on 5 June 2021. The previous audit carried out on 5 May 2021 also identified bathrooms and showers were not clean and the home 'needs deep cleaning'. A staff member told us although this had been raised with the service leader, action had not been taken to make improvements and there was no action plan attached to the audit to show actions had been planned or taken. This meant the home may not be consistently cleaned to the standard for good infection control.

We recommend the provider consider current guidance on the link between cleanliness and infection prevention and control and take action to update their practice accordingly.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● 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.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Staffing and recruitment
● There were enough staff on duty to meet people's needs. Rotas showed that staffing levels were consistent and no one we spoke with said there were not enough staff.
● Due to some permanent staff leaving the service there was a high use of agency staff. The registered manager told us they used the same agency staff as far as possible. Permanent staff were scheduled to work alongside agency staff during the day shift. At night familiar agency staff were used and they worked alone.

● Permanent staff spoke positively about the skills and competence of some of the agency staff. However, staff comments also included, "I think sometimes there could be stronger and more experienced staff. It's OK, but some agency are experienced, and some aren't." Another staff member felt the management of temporary staff needed to be more robust as they did not feel able to give them direction.
● The registered manager told us not all agency staff used at night had completed training in the administration of an emergency medicine for a person who experienced seizures. When this occurred the service then relied on trained staff in the providers other home next door.
● The provider had carried out an audit on 3rd June 2021. This had identified that some staff had not completed safety related training such as moving and positioning, COSHH (Control of Substances Hazardous to Health), fire safety and this was being acted on and monitored for completion.
● Recruitment procedures were in place and followed to help ensure only suitable staff were employed. This included disclosure and barring service (DBS) checks, obtaining up to date references and investigating any gaps in employment. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

Learning lessons when things go wrong
● Incidents were recorded onto an event tracker which enabled the registered manager and provider's quality team to have oversight of incidents/accidents and near misses and monitor for appropriate actions. As described above not all incidents had been reported.
● A process for reporting on trends and sharing learning from incidents was in place but had not been followed recently due to changes in service leadership. The registered manager told us this would be adhered to going forward.

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 the last inspection this key question was rated as good At this inspection this key question has now deteriorated to 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; Continuous learning and improving care

- The registered manager of this service was also a regional manager for the provider, this meant they were responsible for several services and were not based in the service. Day to day management was delegated to a service leader. The last permanent service leader left in March 2021 along with the deputy manager and a temporary service leader was in post from mid-April leaving the service on 16 June 2021.
- Since March 2021 there has been a significant decline in the quality and compliance of the service identified through recent provider audits. In addition, investigations into safeguarding concerns raised with CQC and the local authority between March 21 and June 21 identified improvements were needed at the service.
- Systems and processes in place to monitor and assess the quality of the service were ineffective in driving improvements and there had been a lack of consistent, accountable and effective leadership in the service.
- A medication audit had been completed by a staff member on 10 June 2021. However, this had not identified the issues we found. The IPC audits had identified areas for action, but improvements had not been made in a timely way. This has been further reported on in the safe domain.
- The last registered manager audit was completed in February 2021 at which time the service met the quality performance standards of the provider. Following concerns raised by the registered manager, the quality business partner for the provider carried out an audit on 3 June 2021 when the service was found to be significantly below the quality standards. The provider's audit process had not identified these shortfalls in a timely way and therefore safety issues had been left unnoticed. Following the audit on 3 June 2021 the service leader did not make any progress with the improvement actions identified until they left the service on 16 June 2021.
- This inspection carried out on 17 June 2021 found improvements were needed in the quality and safety of the service which had not been identified by the provider audits and these included concerns with medication, infection prevention and control and incident recording. The rating of this service has deteriorated from good to requires improvement.
- Whilst a system was in place to assess, monitor and improve the quality and safety of the service, it did not enable the provider to identify all areas where quality and safety were being compromised and without delay.

The failure to establish an effective system to assess, monitor and mitigate risks and drive improvements is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

● Following the audit carried out on 3 June 2021 actions for improvements were identified and added to the continuous improvement action plan. Following further concerns raised on 14 June the provider had placed this service into their enhanced support framework. This meant the action plan will be monitored at weekly internal senior management meetings and receive enhanced support from the providers support services and senior management oversight. Notifications were submitted to CQC as required.

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

● The registered manager told us investigations into concerns raised in March 2021 had indicated there were issues in the staff team and the leadership of the service had not supported a positive culture. Following the departure of the management team a temporary service leader was recruited but had not been effective in managing issues within the team. They added, "Although we have had staffing issues, I feel more confident with the staff we have now. I don't feel people have been neglected but there have been disgruntled people and a culture of going to CQC with concerns."

● The registered manager told us that during the past year most of their contact had been carried out remotely due to COVID-19 limiting visits to the service. One staff member who had been in post for a year had not yet met the registered manager in person. Another staff member told us they knew the registered manager, but they were not clear they were the responsible person for the service and should be informed of any safety and quality concerns. Another staff member told us they felt supported by the registered manager and could call them by phone when needed.

● Staff we spoke with told us the priority was the care of the people they supported and although the changes in management had been "Stressful" the remaining team members supported each other.

● Team meetings had taken place in January and February 2021. A staff member told us there had been a team meeting in April solely to welcome the interim service leader but not one since. Team meetings can help to engage staff in shaping and developing the service.

● A relative told us they were aware of issues between staff and these had impacted on their relative's wellbeing. They went on to tell us how communication had deteriorated between staff and between staff and relatives. They had observed some recent improvements and said, "Because of certain people [staff] that are there and knowing that these other people that are there wouldn't let anything happen to [person] without really raising the alarm I feel that [person] is safe." Another relative we spoke to said, "I haven't had any contact with any actual managers for quite a long time and I know there have been a couple of changes but I haven't really needed to [have contact with management]."

● It was apparent from the findings of this inspection, the outcome of investigations and the feedback from staff and relatives the service had not been consistently well-led, and the culture had not always been positive. The provider had appointed a new service leader who was due to take up their post on 5 July 2021.

We recommend the provider consider current guidance on staff engagement to evaluate and improve services and take action to update their practice accordingly.

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 was aware of their responsibilities under the duty of candour, which is a requirement of providers to be open and transparent if things go wrong with people's care and treatment.

● They confirmed there had been no incidents which met the threshold for the duty of candour since the last inspection.

● The registered manager told us they would ensure staff were made aware of this responsibility.

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

● The provider asked staff for feedback on their experience of working for the organisation. However, staff at this service had chosen not to participate in the annual staff survey. A system was available whereby staff could raise concerns and communicate anonymously with managers. In addition, staff could raise concerns anonymously by email or phone. It was not known why staff chose not to use internal processes to give feedback or to raise concerns. The registered manager told us they would be encouraging new staff at the service to use these processes and carry out exercises to improve and encourage a more open culture.

● Throughout the pandemic the registered manager told us 'family webinars' were provided to enable communication to continue with relatives and representatives. This was not used by relatives at this service. We received feedback from a person's relative that communication from the service had deteriorated. "Prior to sort of current events I used to get regular updates … but I did find I was addressing these issues and lots of nods and yes we'll get around to that and no action and this sort of led to concern. – Was I able to contact members of staff and management? yes I was but no I didn't see any results from the contacts I'd made - not the sort of results I would have expected."

● The registered manager acknowledged communication with relatives had not been maintained at the level pre-March 2021 and expected this to improve with new service management. They told us it was difficult to gather meaningful feedback from people using the service but said staff knew when people were unhappy and what they needed. We discussed an example of how a person had become more settled following recent staff changes and a more settled service culture.

Working in partnership with others

● The service worked with a range of healthcare professionals to ensure people received the care and treatment they required.

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 How the regulation was not being met: The provider had failed to assess and do all that is reasonably practicable to mitigate risks to service users which placed people at risk of harm. Regulation 12 (1)(2)(a)(b) The provider had failed to ensure the proper and safe management of people's medicines. Regulation 12 (2)(g)

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 How the regulation was not being met: The provider had failed to ensure systems and processes were operated effectively to prevent abuse of service users. Regulation 13 (1)(2)(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: The provider had failed to establish an effective system to assess, monitor and mitigate risks

and drive improvements to the quality and safety of the service.

Regulation 17 (1)(2)(a)(b)