Achieve Together Limited

Inglewood House

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Inglewood House is a residential care home providing personal care to up to 12 people. The service provides support to people with a range of learning disabilities including people living with autism. At the time of our inspection there were nine people using the service. The home supported all people in one adapted building.

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
This was a targeted inspection that considered safeguarding, infection control, staff training and how information is shared.

Right Support: People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Right Care: People were not always supported where there was a safeguarding concern. There had been a recent incident that had not been dealt with appropriately. This meant people had been left at risk of further safeguarding concerns for longer than necessary. Following this incident further training and support had been given to the staff team.

Right Culture: Information had not always been shared in a timely way. This was not in line with the culture of the home to include other professionals in significant events to ensure a good level of care for the people living in the home.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate (published 25 May 2022) and there were breaches of regulation. CQC have met with the provider and the local authority as part of the location entering 'special measures'. We only looked at specific areas at this targeted inspection which only included one of the previous identified breaches of safeguarding service users from abuse and improper treatment. At this inspection we found the provider remained in breach of this regulation.

Why we inspected

The inspection was prompted in part by notification of an incident following which a person using the service sustained harm. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of safeguarding, reporting and training. This inspection examined those risks.

We use targeted inspections to follow up on Warning Notices or to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating

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 provider has taken action to mitigate the risks, however, at this early stage we are unable to confirm if this is effective.

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

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

At the last inspection we recognised that the provider had failed to deliver person-centred care, treat people with dignity and respect, ensure people always gave consent, deliver care and treatment safely, safeguard service users from abuse and improper treatment, acting on complaints, have good governance and have adequate staffing at the home. These were breaches of regulations 9, 10, 11, 12, 13, 16, 17 and 18. Full information about CQC's regulatory response to this is added to reports after any representations and appeals have been concluded.

Follow up
We will 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review. The service has existing conditions on their registration, and as we do not propose to cancel the registration, we will monitor the provider's monthly submissions. We will reinspect within six months of the last comprehensive report (published May 2022) 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?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Is the service effective?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Inglewood House

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.

This was a targeted inspection to check whether the provider had met the requirements of the previous breach in relation to Regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was also to check on a concern we had about a delay in action and reporting of a serious safeguarding concern.

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 two inspectors.

Service and service type
Inglewood House 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. Inglewood House 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 not a registered manager in post.

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 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 spoke with four people who used the service about their experience of the care provided. We also observed interactions between staff and a number of other people who used the service. We spoke with nine members of staff including the temporary acting manager, regional manager, senior care workers, care workers and agency care workers.

We reviewed a range of records. This included daily handover sheets, accident and incident reports, safeguarding records and service user's daily notes. We also looked at a variety of records relating to the management of the service, including policies and procedures were reviewed.

Inspected but not rated

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 this key question was rated inadequate. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check a concern we had about safeguarding people from harm and the risk of harm. We will assess the whole key question at the next comprehensive inspection of the service.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure people were protected from abuse and neglect. This 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.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13

● People were not always protected from abuse and neglect. There had been a recent incident where a serious safeguarding concern had been identified by staff and this had not been reported in a timely way. This meant police and other professionals did not know about the concern immediately to take action to safeguard the person.
● Staff did not always document the sharing of information with each other. For example, the handover between staff shifts were verbal and not always written. This meant that pertinent information about people could be forgotten or misplaced and placed people at risk of neglect.

People continued to be at risk of abuse and neglect. This 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.

The provider responded immediately during and after the inspection. They confirmed a written handover was introduced and completed twice daily to ensure staff shared all important information in a safe way. Following the recent concerns senior management took immediate action, and notifications were made. Senior management engaged with the Police and local authority safeguarding professionals and continue to work with them.

● Since the recent serious safeguarding incident staff had received additional training and discussions with the management team. Staff were confident they would be able to report any safeguarding concerns in a timely way.
● One staff member said, "If anything is wrong, I would go to permanent member of staff and then in the morning to the manager. If concerns, would also raise it in the handover. This is really important to get to

handover to see what has happened during the day." Another staff member said, "If I see anything that I think is not right or that I am worried about, I will go to whoever is leading the shift and speak to them. I don't write it down, hand it over verbally. I do fill in an accident and incident form. I think when I pass any concerns on, they are taken seriously and discussed in handover so that they (staff) are all aware."

● People told us they felt safe. One person said, "I feel safe here among my friends. The staff are nice and kind, this is a happy house. I would speak to [Manager] if I didn't feel safe. I know he would help me".

Preventing and controlling infection

● 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 promoting safety through the layout and hygiene practices of the premises.

● 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

● The care homes approach for visitors was in line with current government guidance. People and their relatives were positive about their experience of visiting and being able to see their families throughout the pandemic.

Inspected but not rated

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 our last inspection this key question was rated inadequate. We have not changed the rating as we have not looked at all of the effective key question at this inspection.

The purpose of this inspection was to check a concern we had about sharing information and staff training. We will assess the whole key question at the next comprehensive inspection of the service.

Staff support: induction, training, skills and experience; Staff working with other agencies to provide consistent, effective, timely care

At our last inspection the provider had failed to ensure staff received appropriate training and supervision. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● Following a recent serious incident, staff had not followed directions detailed in training courses. They had failed to effectively use their experience to immediately alert other professionals to an incident that had occurred in the home. This meant that the training had not been effective for staff to understand and act accordingly.
● Staff had failed to show their skills and experience when faced with a serious concern. There had been a delay in sharing important and essential information with professionals who could effectively support people through a serious incident.

This was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed all staff had received immediate updates in how to report safeguarding concerns and all staff were undergoing competency checks and supervisions so the provider could be assured of improved procedures.

● One staff member told us, "I can't believe that a delay in reporting happened. We are trained to follow the safeguarding policy which is to report immediately." Another member of staff said, "I would report any safeguarding concerns immediately. And if I felt it wasn't being dealt with properly, I would immediately escalate. We need to make sure everyone is safe, that is one of our primary roles."
● Since the incident the provider had been working closely with the local authority. A social care professional said, "There have been major failings, however, it is how they respond now. And it honestly

appears as they are responding well and doing everything to make positive changes for the home and the people living there."

● Staff received other specialist training in line with the needs of people living in the home. This included epilepsy training and specialist medicine training such as buccal administration (a medicine used to manage seizures).

● New members of staff completed training in line with The Care Certificate. This is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

● We observed new members of staff and agency staff 'shadowing' more experienced members of staff. This ensured new members of staff could be as effective as possible to carry out their roles.