Individual Care Services

Individual Care Services - 60 Ward Grove

Inspection report

60 Ward Grove
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

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.

About the service
Individual Care Services – 60 Ward Grove is a residential care home based in a small cul-de-sac within a small community. It provides accommodation and personal care to a maximum of 3 people with a learning disability and/or autistic people. At the time of our inspection, 3 people lived at the home.

People's experience of using this service and what we found
People did not always receive person centred care in line with Right Care, Right Support, Right Culture.

Right Support: People were not always involved in making decisions about their care. There was limited consideration given to the varying ways people could be empowered to make their own decisions and choices using different communication methods. People were not always supported to have maximum choice and control of their lives and records did not always show decisions had been made in people's best interests.

Right Care: Risks to people's health and well-being had been identified and assessed, but not always managed safely. Healthcare professional advice was not always followed or implemented effectively. The provider used a high number of temporary staff supplied through an agency who had not always received the same level of training as the permanent staff which impacted on people's care.

Right Culture: The provider did not always promote a person-centred culture which empowered people to make their own decisions. Systems were not always operated effectively to identify if people were receiving care and support in line with Right Care, Right Support, Right Culture. Feedback from a variety of sources indicated people did not always feel able to raise concerns because they were not confident their views would be responded to positively.

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 17 October 2018).

Why we inspected
We received concerns in relation to the application of the Mental Capacity Act 2005. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

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

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 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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Individual Care Services – 60 Ward Grove on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to consent, safe care and treatment 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 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? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Individual Care Services - 60 Ward Grove

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 2 inspectors.

Service and service type
Individual Care Services – 60 Ward Grove 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. Individual Care Services – 60 Ward Grove 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 no registered manager in post.

Notice of inspection
We gave the service 2 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider would be in the office to support the inspection.

Inspection activity started on 24 August 2023 and ended on 4 September 2023. We visited the service on 24 August 2023.

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. This information helps support our inspections 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 2 relatives and a person's advocate about their experience of the care provided. We spent time with the 3 people who lived at the home observing the quality of care and support they received. This helped us to understand the experiences of people who we were unable to communicate with us. We spoke with 8 members of staff including the service manager, the Head of Care, 3 support workers, 2 temporary staff supplied via an agency and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke to 4 healthcare professionals about their experience of the care provided.

We reviewed a range of records. This included information contained in 2 people's care and medicine records. We also looked at 1 staff recruitment file and records related to the overall management and quality assurance of 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.

Assessing risk, safety monitoring and management; Using medicines safely
● Risks to people's health and well-being had been identified and assessed but not always managed safely.
● A healthcare professional had recommended 1 person avoided 'flaky and crumbly' foods due to their health condition. This information had not been transferred into the person's risk assessment or care plan. Records showed staff had given this person biscuits, crackers and sausage rolls in the months prior to our inspection without an appropriate rationale which placed the person at risk of harm. We recommended urgent advice was sought to ensure these foods were safe for this person.
● This person was also at risk of constipation and required medication to be administered if they had not opened their bowels within a 24-hour period. Records showed this medication had not always been given in line with their care plan, placing the person at risk of harm.
● A healthcare professional had recommended a specific plan for how to best position a person on their bed to mitigate risks associated with their posture. This was not being followed at the time of our visit.
● Another person was at high risk of skin damage. Records stated they should have bed rest every other afternoon. Staff told us the person regularly declined bed rest, but there was no guidance to mitigate this additional risk within their care records.
● One person's daily records indicated there could be occasions when they demonstrated their anxiety or distress through their responses to other people and staff. There was very limited information about the actions staff should take to support this person's emotional wellbeing at such times. This was a particular risk due to the high use of temporary staff supplied via an agency within the home.
● The provider had installed a 'de-choker' device in the home without adequately assessing the risks associated with the use of this device. A 'de-choker' is an airway clearing device that can be used in choking emergencies.

The provider had failed to assess the risks, and do all that is reasonably practicable to mitigate risks associated with the health and safety of people using the service. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Following our feedback, the provider took some immediate actions to ensure people remained safe. Important information about risks associated with people's care was updated in people's care records, an urgent request was made to review a person's eating and drinking guidance and the 'de-choker' device was removed until the provider could adequately assess if this was suitable for use.
● Regular health and safety checks were completed to ensure the environment and equipment remained safe.

● Overall, medicines were stored and managed safely. Staff who administered medicines had been sufficiently trained and their competency to administer medicines had been regularly assessed.
● However, when people's medicines were received in the home, records did not always show these had been checked for errors in line the provider's expectations. The Head of Care told us they would ensure this was completed going forward.

Systems and processes to safeguard people from the risk of abuse
● The provider had a policy to safeguard people from abuse. However, we found 1 occasion where this policy had not been followed and the provider had not reported a potential safeguarding incident to the local authority. We discussed this with the Head of Care who confirmed learning had taken place from this to prevent re-occurrence.
● The provider had not always worked within the principles of the Mental Capacity Act to ensure people's human rights were upheld. It was not always clear if people had been involved in decisions about their care. We report more on this in the effective section of this report.
● The provider acted as an appointee for 1 person living at the home. Although we found no evidence of misconduct, the provider had not done all that was reasonably practicable to mitigate risks of financial mismanagement. For example, there was no policy, risk assessment or evidence of an appropriate best interests decision.
● Despite this, people appeared comfortable and relaxed in the presence of staff. Staff knew people well and understood their day-to-day role in protecting them from the risks of abuse. One staff member told us, "Safeguarding is about protection. Providing a safe space to vulnerable people who cannot always help themselves."

Staffing and recruitment
● There were enough staff to provide safe care. Each person living at the home received one to one support from staff throughout the day to ensure their needs were met. However, due to difficulties recruiting staff, the provider was heavily reliant on staff supplied through an agency.
● Staff told us the required staffing levels were maintained but the reliance on agency staff presented difficulties in providing high quality care. For example, in the continuity of care people received and the reduced number of staff able to drive a vehicle to meet people's social needs. The Head of Care told us they tried to book familiar and regular temporary staff where possible, and service managers would support if a driver was not on shift to support people's social needs.
● Staff were recruited safely. Pre employment systems included reference and Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

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
● People were supported to maintain contact with their family and there were no restrictions on visiting.

Learning lessons when things go wrong
● There had been no reported accidents or incidents since our last inspection visit. However, staff understood their responsibility to report and record accidents and incidents in line with the provider's expectations.

Requires Improvement

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 we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

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

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The service was not working within the principles of the MCA and associated code of practice to ensure decisions made on behalf of people were in their best interests.
- Staff recognised people had not always been given the support required by the MCA to make their own decisions and express their preferences.
- Prior to our inspection, we received concerns holidays were booked for people without seeking their views. We found no evidence people had been involved in choosing their holiday destination. Mental capacity assessments had not been completed and there was no record of the decision being made in people's best interests in line with the requirements of the MCA.
- The provider could not evidence all practicable steps had been taken to support people to make important decisions, or that information about people's care and treatment was provided to people in a way they could understand to support them to make their own choices.
- Due to a health condition, 1 person had a visual monitor in their bedroom to observe them whilst they slept. Whilst a basic capacity assessment had been completed, this did not evidence that other, less restrictive options had been considered or that it had been regularly reviewed.

We found no evidence that people had been harmed however care and treatment was not always provided with consent. This placed people at risk of harm. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The service manager and staff liaised with other agencies and health professionals to meet people's specific needs. However, healthcare professional advice was not always implemented effectively.

● There was no central record of people's healthcare visits. This meant it was difficult to obtain an up-to-date picture of people's current health and when future healthcare appointments such as dentistry were due.

● People had hospital passports which recorded important information about people's health needs should they require urgent admission to hospital. However, some contained inaccurate information such as what medication people were prescribed. The service manager agreed to update these following our visit.

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

● The provider was in the process of introducing a new electronic care planning system. However, none of the staff on duty understood how to access the system, nor did they have access to paper copies of people's care plans. This put people at risk of not receiving effective care. Immediate action was taken to print copies of people's care plans for staff to refer to after our inspection visit.

● One 1 person had recently moved into the home. There was limited evidence to show this person's care and support had been properly planned and co-ordinated when they moved into the home. One staff member told us, "I don't think the transition was done properly. We didn't have much information about [person]. We went to visit them twice and they [previous home] didn't know we were going."

● Further, there was no recorded assessment to check the person's compatibility with the 2 other people already living in the home or that their views had been sought.

Staff support: induction, training, skills and experience

● Staff completed an induction when they started to work at the home. This included working alongside experienced members of staff for them to get to know people's differing routines.

● The induction included training to achieve the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of staff in health and social care.

● Records demonstrated staff were up to date with the provider's mandatory training. This included important topics such as safeguarding and autism awareness.

● However, agency staff had not always received the same level of training as permanent staff which impacted on people's care. For example, one person had been advised by a physiotherapist to carry out a range of defined exercises 3 times a week. This person was not following their exercise regime because not all staff had received the training required to support the person with this regime. Another person had an issue with their stoma bag, but the only staff member on shift had not been trained in stoma care.

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

● Records showed people had enough to eat and drink. We saw staff responded to people's needs when people were hungry or thirsty.

● Staff offered a varied diet which considered people's individual needs. For example,1 person required foods high in iron which was encouraged.

● However, staff did not always follow people's nutritional plans to maintain people's independence around eating and drinking. Records stated 1 person should be encouraged to eat independently with adapted cutlery. This was not encouraged on the day of our visit. An agency staff member placed food into the person's mouth without encouraging their independence.

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

● People had individual bedrooms and shared communal bathroom facilities. People's bedrooms had been decorated to reflect their individual preferences and interests. One person had sensory equipment in line with their needs.

- Two bedrooms had a ceiling hoist to support the safe moving and transferring of people in and out of bed.
- Each person had their own specialist wheelchair. We saw and staff confirmed it was sometimes a challenge moving people around the home in their wheelchairs because of limited space in communal areas. The provider's Head of Care told us plans were being developed to provide more open communal areas which would better meet people's needs.

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 good. At this inspection the rating has changed 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There had been a period of managerial instability at the home. At the time of our inspection, there was no registered manager in post, the service manager was working their notice period and there were no senior support workers to oversee the safe running of the home.
- The Head of Care had taken interim day to day managerial responsibility to oversee the home but was also responsible for the quality of care delivery across the whole provider group.
- We reviewed the service in line with CQC's closed culture guidance and were concerned there were risk factors for a closed culture to develop. Feedback from a variety of sources indicated people did not always feel able to raise concerns because they were not confident their views would be responded to positively. Feedback included concerns the provider was not approachable, did not promote an open and inclusive culture or uphold the rights of people living in the home.
- The provider did not always demonstrate person-centred culture which empowered people to make their own choices in line with Right Care, Right Support, Right Culture. The provider had failed to maintain sufficient and accurate oversight of the service to identify regulations and legislative requirements within the Mental Capacity Act 2005 were not being met.
- Accurate records were not always kept regarding people' care and support needs. It was not clear how people, and where appropriate their relatives and other professionals, had been involved in decisions about people's care. Where people lacked capacity to make decisions, it was not always clear decisions had been made in people's best interests.
- The provider's systems and processes for monitoring the quality of the service were not always used effectively. The issues found at this inspection had not been identified through internal quality monitoring audits and checks. This put people at risk of their needs not being met due to ineffective oversight and governance systems. For example, ensuring healthcare professional advice was followed.
- During the inspection we found 1 significant incident had not been reported to us, CQC, in line with the providers regulatory responsibilities. The Head of Care submitted this notification retrospectively.

There was a lack of effective oversight and governance which meant people had not received high quality, person centred care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some immediate actions had been taken following our inspection visit. The provider had started to

implement new policies to improve the service delivered at the home. These included how people's holidays would be planned in line with the Mental Capacity Act 2005 and how appointeeships were managed.
● The Head of Care updated people's care plans to reflect healthcare professional advice and met with the staff team to ensure all staff working in the home knew how to support people in line with this advice.

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
● Improvements were still required to ensure an environment was created where there was an open culture at all levels. However, we found no evidence to suggest duty of candour had not been followed for significant incidents in the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There were missed opportunities to engage with people and we found limited evidence of people being involved in their care.
● Staff had opportunities to be involved in the day to day running of the home via informal discussions and team meetings.

Working in partnership with others
● Records did not always demonstrate how the provider worked in partnership with other agencies.
● During the inspection we saw an email where a positive relationship with external professionals was not promoted by the provider.

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 11 HSCA RA Regulations 2014 Need for consent 11(1) The provider had failed to ensure care and treatment of service users must only be provided with the consent of the relevant person. 11(3) The provider had failed to act in accordance with the 2005 Act.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12(2)(a) The provider had failed to assess the risks to the health and safety of service users of receiving the care or treatment; 12(2)(b) The provider had failed to do all that is reasonably practicable to mitigate any such risks

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 17(1) The provider failed to ensure systems or processes were established and operated effectively to ensure compliance with the requirements in this Part. 17(2)(a) The provider had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); 17(2)(b) The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; 17(2)(c) The provider had failed to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; 17 (2) (e) The provider has failed to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;

The enforcement action we took:

Warning Notice