Four Care Plus Limited

Prospect House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Prospect House is registered to provide accommodation and personal care for up to seven people living with a learning disability. The care home accommodates people in one building. At the time of our inspection there were six people using the service.

People's experience of using this service and what we found
Significant shortfalls were identified in the governance of the service. Systems were in place to check the service was working to the provider's expected standards. However, where the checks had been completed, they were not effective and did not identify the concerns we had raised as part of this inspection. There was a lack of provider oversight of the standards at Prospect House.

People were not always kept safe. We found concerns with the safe management of risk for areas including people who show behaviour that may challenge others, eating and drinking, epilepsy and uncovered radiators.

People were not consistently kept safe from the risk of abuse or neglect.

Staff deployment was not sufficient to meet people's needs safely.

Infection control concerns were identified in relation testing, assessing risk and PPE.

Lessons were not being consistently learned and similar issues to those highlighted at other inspections, carried out by CQC and other organisations such as the local authority were found at this inspection.

Staff training was not effective as some staff did not have a good understanding of some people's needs and the support they would need, for example if the person was living with autism.

People's health needs were not accurately recorded and updated.

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

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of

Right support, right care, right culture. People were not always living meaningful lives that include control, choice, and independence. People using the service did not receive planned and co-ordinated person-centred support that was appropriate and inclusive for them resulting in them in receiving poor standards of care. The provider submitted an action plan following our inspection giving details on how they intended to improve the standards at Prospect House.

Right support:
• Model of care and setting did not maximise people's choice, control and Independence

Right care:
• Care was not always person-centred or promoted people's dignity, privacy and human rights

Right culture:
• Ethos, values, attitudes and behaviours of staff did not ensure people using services lead confident, inclusive and empowered lives

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 requires improvement (8 April 2020 last report published) At this inspection we found improvements had not been made and sustained, and the provider standards had declined further and the service is now rated inadequate. The service has remained rated either inadequate or requires improvement for the previous five inspections.

Why we inspected
We undertook this inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about safety and governance. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with safety, governance, staffing and safeguarding, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe, effective, caring, responsive and well-led.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, good governance, staffing and person-centred care 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 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 overall rating for this service is 'Inadequate' and the service in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Prospect 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 Care Act 2014.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Prospect House 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, at the time of the inspection. 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
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 also gathered feedback from local authority contracts and the commissioning team.

We used all of this information to plan our inspection.

During the inspection

We visited Prospect House on the 18 and 27 January 2021 and looked at care records that the provider sent to us. We spoke with four people who used the service about their experience of the care provided. We spoke with seven members of staff including an area manager, deputy manager, senior support workers, support workers and agency support workers. We carried out observations of interactions between people and staff to help us to understand the experience of people who could not talk to us.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with one professional who has visited the service. We spoke with three relatives and four staff over the telephone and we discussed the service with the nominated individual who is responsible for supervising the management of the service on behalf of the provider.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Learning lessons when things go wrong; Assessing risk, safety monitoring and management

- Risks associated with people's care and treatment had not always been identified and managed safely. For example, one person was at risk of choking and they were left unsupported whilst eating their meal.
- People were not sufficiently protected from harm. Risk assessments had not identified shortfalls we found on inspection or were not being followed. We saw one person being given a hot drink which could have led to them being scalded. The risk to this person had not been considered.
- There were frequent incidents where people displayed behaviours which may challenge others. Incidents were not effectively monitored and analysed to ensure that actions were taken to reduce the risk of incidents happening.
- We identified that some radiators were left uncovered. This could have posed a risk of burning to some of the people living at Prospect House. However, this had not been identified through the providers health and safety monitoring or assessments of risk. The provider acknowledged the risk and took action to address this.
- Lessons were not being learned and improvements were not maintained or sustained.
- Environmental checks in relation to fire safety, gas safety and electrical safety were in place, however at the time of the inspection records that all legionella checks were taking place were not available. They were later located to provide evidence legionella checks were being completed.

Preventing and controlling infection

- Shortfalls were identified with the system the provider had in place with testing staff for COVID-19. This meant that staff were tested but did not receive their test results back to give assurance to ensure they were free from the virus.
- Staff were not always wearing a face covering correctly. On both days of our inspection we saw staff wearing masks underneath their nose.
- Contaminated waste was not disposed of correctly to prevent the risk of infection spreading.
- The deputy manager was unable to locate a policy on infection control which meant there was not a copy readily available to refer to. There had been no assessment of risk carried out for staff who could have been disproportionately affected by COVID-19.

Systems and processes to safeguard people from the risk of abuse

- People were not always safe from the risks of abuse.
- Staff had received training in safeguarding but did not always recognise and respond to safeguarding incidents appropriately. Following our inspection, we asked the provider to make three referrals to the local

authority safeguarding team.
● Systems and processes did not operate effectively to prevent people suffering from abuse. There is further information relating to this in the well led section of this report.

Staffing and recruitment
● The deployment of staff was not appropriate to meet people's needs. Staff did not always respond to people in a timely way and staff regularly left people they were supporting to complete other tasks. A relative said, "During the summer when it was nice weather, they didn't have enough staff to take [relative] out.''
● One staff member said, "Sometimes we are short, staff will leave you in the lounge to look after people. This makes the job hard." Another staff member said, "We are short of staff and we are struggling to get training done. We are having to do extra hours and we come in on days off." Staff told us they felt they were working short due to reduction in staffing levels.
● The provider was reliant on the use of agency staff. We found that agency staff were supporting people without always knowing their needs and preferences. Agency staff had not received suitable induction to the service and had not been given time to read key documents on how to support people.
● We found shortfalls in the providers recruitment process. We were not assured all staff had been safely recruited. Some staff files had been audited and marked as compliant, however we found one file that didn't have sufficient references in place.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This 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 responded during and after the inspection. They confirmed all the shortfalls identified by the inspection would be actioned.

Using medicines safely
● Staff were unclear on when to give medicine administered as and when required to people who were experiencing pain. Medicines protocols needed further developing for staff to know the indicators of pain and how to respond.
● People had medicine cabinets in their own room and storage was secure.
● There were clear systems and processes in place to ensure medicines were managed safely. There were clear and regular checks of stock balances and audits of procedures.
● Medicines audits happened regularly, and action was taken where medicines issues were identified.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience
- Staff were not suitably competent or skilled. The provider's training plan showed several staff were not recorded as having completed any training relevant to their job roles.
- Staff had received training on positive attitudes and behaviours but despite this the culture in the home was not positive and poor practice was not recognised.
- Staff lacked knowledge around how to support people with behaviours that may challenge others. The provider's training policy stated, 'All staff who have been trained in breakaway and / or physical Intervention techniques must attend an update session 3 months after their initial training and then at least once every twelve months.' This had not taken place leaving staff unequipped to support people in potentially risky situations.
- Staff did not always have a basic understanding of people's needs. Staff had not recognised there was a choking risk to one person despite having completed dysphagia training.
- There was a lack of staff supervision and competency observations to check staff had the relevant skills, experience and ability to support people. The provider's policy set out timescales that staff should receive supervision and appraisal and these timescales had not been achieved.

Staff lacked the training, competence and skills to support people safely. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2001 (Regulations 2014

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support
- The quality of information detailed in care plans did not meet people's needs. For example, we saw one person had epilepsy but there was no available care plan and staff were left supporting a person who had regular seizures with no instructions or guidance. We also found that behavioural management plans were not sufficiently detailed to ensure people were supported in line with best practice guidelines.
- Restrictive interventions were being carried out and the provider did not have restrictive intervention reduction plans in place. This goes against National Institute of Clinical Excellence (NICE) guidelines on Violence and Aggression.

Staff working with other agencies to provide consistent, effective, timely care
- Health action plans for people lacked detail. Accurate records relating to health were not maintained. This meant people's health needs could be overlooked. For example, we looked at seizure monitoring records for one person and they contained conflicting information on the frequency of seizure activity.

● Relatives had raised concerns about staff attending health appointments unprepared and unable to handover information about their relative's health and wellbeing.

Adapting service, design, decoration to meet people's needs
● The environment was decorated in a pleasant way and it felt homely.
● The available space in the home was not best utilised. There was a large activities room and a quiet lounge, but this space was not being used.
● People's rooms had been personalised with items meaningful to them.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
● There was a record of DoLS applications that had been received and followed up where necessary.
● People didn't always have the freedom to make their own choices and staff lacked awareness regarding the mental capacity act.
● Decisions were made on people's behalf and not done in consultation with others. A formal decision-making process or a record of decision was not made following the principles of the MCA, specifically around supporting people with behaviours that may challenge others.

We recommend the provider considers current guidance on MCA and takes action to update their practice accordingly.

Supporting people to eat and drink enough to maintain a balanced diet
● People chose what they wanted to eat, and staff supported some people to prepare their food and drinks.
● The mealtime experience was at times chaotic; people were often shielding their plates to prevent food being taken from them. We discussed this with the provider and a plan was put in place for people to sit in a quieter environment if they chose to do so.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- There was a lack of social stimulation to meet people needs and preferences. This was impacting on people's mental health and well-being.
- Staff said that often there was a lack of drivers on shift limiting access to the community for people who required the use of the vehicle.
- People were not always supported to follow their interests or encouraged to take part in social activities, or to maintain relationships. We recognise the COVID-19 pandemic had impacted on social activities, however people told us they were unable to go out. One person said, "Having to stay in the house makes me bored stiff and I couldn't go out yesterday as there was not enough staff on shift to take me out."
- Activities were not planned or coordinated in line with meeting people's needs and preferences. We saw one person who was ready to go out having to wait until staff finished other tasks. The person's communication needs meant waiting started to cause them to be anxious.
- Records showed people had very limited access to meaningful activities.

Ensuring people are well treated and supported; respecting equality and diversity

- People were not always respected as individuals and their rights were not always upheld. A number of records showed that staff felt that people had become anxious due to staff "telling a person off" and the person "not listening to staffs' instructions".
- People's privacy and dignity was not always maintained. Staff were aware when people wanted time alone in their room, however this was not always respected.
- A closed culture had developed within the service. A closed culture is a poor culture in a health or care service that increases the risk of harm. This includes abuse and human rights breaches.

The provider failed to provide person centred care and support meaning that people's needs, and preferences were not met. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some kind and caring interactions were seen. Staff did encourage some people to develop their independence. For example, taking part in preparing a meal and cleaning their room.
- Staff told us they cared about the people they supported. One staff said, "I enjoy looking after people, I like to make sure they have good care. I like to see people happy."
- Relatives said, "I think they [staff] are caring. The long-standing staff are really good. I don't think they get

the recognition they deserve, feel staff need more support than they get. I see them as extended family."
● Information about people was kept confidential. We saw people's personal information locked away in offices and offices were kept locked when not in use.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

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 people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People's care records did not recognise people's differences based on the protected equality characteristics.
- Not all staff had read people's care plans and care plans weren't always followed. People were often supported by staff that didn't know their needs and preferences well.
- Staff failed to understand people needs and there was a lack of understanding regarding best practice when supporting people who displayed behaviours that may challenge others. We saw written examples of people being unnecessarily restricted, by being asked to go to their room, when this could have been avoided.

Improving care quality in response to complaints or concerns

- The service had a complaints procedure in place for people and those acting on their behalf to use, if they had a concern or were not happy with the service. This system was not effective.
- Relatives told us they didn't feel listened to and complaints were not taken seriously. One relative said, "There's always issues, I speak up. [Managers] do not listen and speak over you half the time." Another relative said, "I wish they would listen to parents' concerns. I have raised issues formally with managers and I'm concerned about their professional status. Staff are not being led, it's terrible communication a recipe for disaster. It's dangerous as my [relative] doesn't have a voice so they need to listen to relatives."
- Not all complaints were logged, and information was not available to ensure lessons from complaints had been used to drive improvements.

We recommend the provider takes appropriate action to update their practice accordingly.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their careers.

- Information was available in an accessible format for people. We saw easy to understand information on display such as some pictures and photographs to help people understand information.
- Support plans contained information on how people communicated but the level of detail around communication needed more detail to assist and instruct staff on how to best meet people's needs, specifically when they presented behaviours that may challenge others.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

In advance of our inspection, we had received information of concern about the management of the service and the staff culture. We reviewed these areas during this inspection and identified concerns and shortfalls.

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

- The lack of monitoring of staffs' practice increased the risk of people receiving unsafe or poor care. We saw shortfalls in staffs' practice in a number of areas which went unobserved by senior staff.
- There was no way to be sure if all key information about how to support people had been provided to agency staff. This was because most of the agency staff in the home did not have a written record of their induction. There had been no recent monitoring of agency staff records and although previous checks had highlighted shortfalls in records, these remained unresolved.
- Monitoring and review of people's care records had not always been carried out consistently or been effective.
- The deputy manager told us they had not found time to complete some audits and had fallen behind with them. This included monthly manager's audits, designed to monitor the quality and safety of the service. The monthly audits of people's health care had not been completed.
- Audits of people's care plans and records had failed to identify issues around safety and health. There was inadequate management oversight of the culture in a service.

Working in partnership with others

- There had been instances when staff in the home did not share information effectively with health care professionals.
- Feedback from a visiting professional in October 2020 had not been acted upon. We found the same and similar shortfalls in mattress audits, care plans, behaviour monitoring and oversights of people's weight. For instance, two people had had significant changes in their weight, but there was no evidence this had been explored or considered when their care plans and risk assessments were reviewed.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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 service has a history of breaching regulations. Shortfalls related to governance had been noted at the five previous rated inspections of the service. The service was rated as inadequate in 2017 and in 2019 and rated as requires improvement in 2016, 2018 and 2020. This indicated a pattern of failure on behalf of the

provider to ensure improvements were sustained. This inspection highlighted similar areas of concern.
● The service was not well led. The provider had poor oversight of the service and demonstrated a lack of awareness of some of the issues which we highlighted at this inspection.
● The registered manager and the service development manager (deputy manager equivalent role) had been absent from the service. The deputy manager was managing the service on a day to day basis. It was evident they were struggling to keep on top of all the management responsibilities that resulted from the absence of their colleagues. They were receiving some support from senior management, but this was not enough to assist them with running the service.
● Despite assurances from the provider that the deputy manager was receiving enhanced management support, at the time of the inspection the deputy manager had not received formal staff supervision for over six months.
● Quality management systems were not effective, with gaps in auditing and monitoring. Significant concerns were identified throughout the inspection process. However, these had not been highlighted or addressed through the provider's auditing and monitoring process.
● Incidents were not always looked into by an impartial person which meant that the cause was not identified and addressed appropriately.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The last quality survey to ask people, and those close to them about their satisfaction with the service was undertaken in 2019. At that time there was some feedback that people were bored. People told us they were bored during this inspection and we saw that levels of engagement and activity were not high. This meant that feedback form people had not been actioned upon to improve people's experience of using the service.
● We received mixed feedback from people's relatives about whether their feedback was used to improve the service.
● Meetings for people who used the service were held but their feedback was not acted upon to improve the service. There were recent gaps in evidence of people's involvement in their assessments and plans. This did not reflect a person-centred service.
● Areas for improvement were identified at the last inspection in the culture in the home, and staff attitudes and behaviours. The deputy manager told us there remained a need for improvement in these areas. We noted some signs of friction between staff, which sometimes caused an atmosphere of tension in people's home environment.
● We received mixed feedback from staff about the support provided to them by managers. Some staff said they felt they were not listened to. One staff said, "I feel like when you mention some things they don't get solved. Staffing issues aren't dealt with. Staff are leaving."

The well led domain had not been rated good for the last five inspections. There was a lack of effective management oversight and effective system in place to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They sent an action plan detailing how they intended to make improvements and sent weekly updates on progress made.

● Staff confirmed there were reasonably regular team meetings and records provided to us confirmed this.
● The deputy manager told us they were committed to making improvements. However, they acknowledged their need to develop further in their own role before taking on significant management duties and responsibility.