Care Quality Commission

Zero Three Care Homes LLP

Imola

Inspection report

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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
Imola is a care home that provides care and support for up to eight people who have a learning disability or who are autistic and have complex support needs. At the time of the inspection there were eight people living at Imola.

People's experience of using this service and what we found
We observed people engaging positively with staff who were committed to promoting their wellbeing. We received largely positive feedback from relatives, who spoke warmly of the support their family members received, particularly from established staff who knew people well.

There had been changes at Imola since our last inspection. There was a new registered manager, deputy and new care staff. The provider had systems in place to check the quality of care and of the accommodation, however these were not always effective. We had concerns around how well some risks were managed across the service, including poor infection control. The provider had also not submitted the notifications and safeguarding alerts to CQC and the local authority, as required.

There were not always enough experienced and skilled staff on each shift. Some families and staff told us this affected the quality of care people received. Prior to our inspection the provider had already started to take action to address staffing retention and practice.

The provider was open to our feedback and demonstrated a commitment to improving care and safety at Imola. They had set up workshops to promote people's quality of life, which were positive and reflected a commitment to promoting person-centred care. Despite some concerns around infection control, the provider and staff had worked hard to promote people's wellbeing during the COVID-19 pandemic. The provider engaged well with external professionals to make decisions in people's best interests.

Staff knew what to do when they had concerns about people's safety. The provider carried out investigations into safety concerns and incidents, making changes to people's care as required. Individual risk assessments were personalised and provided practical guidance to staff.

People received support to take their medicines safely, and to reduce unnecessary use of medicines.

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.

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.

This service was able to demonstrate how they were working towards meeting the underpinning principles of Right support, right care, right culture.

Right support:
The model of care and setting maximises people's choice, control and Independence. There is a demand for the type of service Imola provides as it enables people to move out of more restrictive accommodation, such as long-stay hospitals. The provider is working to ensure the property does not feel institutional and meets people's sensory needs and preferences.

Right care:
Care is person-centred and promotes people's dignity, privacy and human rights. People are treated as individuals and care is provided flexibly in line with their preferences. The provider works in line with guidance around Positive Behaviour Support to provide care which minimises restrictions to people's freedom.

Right culture:
Staff and management seek to promote a positive ethos, values, attitudes and behaviours which enable people using services to lead confident, inclusive and empowered lives. High staff turnover has meant it has been challenging to establish a consistently positive culture.

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 30 April 2019).

Why we inspected
We received concerns in relation safety, a medicine error and the culture at the service. 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.

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 sections of this full report.

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

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.

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.

At this inspection we have identified breaches in relation to the lack of oversight and management of risk and in relation to the provider's failure to send CQC notifications as require.

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? The service was not always safe. Details are in our safe 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**

Care Quality Commission

Imola

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
The inspection team included two inspectors.

Service and service type
Imola 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 newly 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
The inspection was unannounced. Inspection activity started with the care home visit on 12 July 2021 and ended on 22 July 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan

to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
Two inspectors visited Imola on 12 July 2021. They met with the registered manager, the deputy manager, the area manager and eight care staff.

We reviewed a range of care records, including five people's selected care and medicine records. We looked at three staff files in relation to recruitment, staff supervision and training. We reviewed a variety of records relating to the management of the service.

After the inspection
After the site visit, we continued to collect information from the provider. We also had a phone call with the registered manager, area manager and two directors of the company, one which was the provider's clinical psychologist.

We had email or phone contact with four family members and five staff. We sought feedback from the local authority and professionals who work with the service and had contact with four health and social care professionals.

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.

Preventing and controlling infection

• We were not fully assured the provider was preventing visitors from catching and spreading infections. Families described safe visiting arrangements. However, staff who greeted us did not follow the provider's procedures for welcoming guests during a pandemic. Forms and thermometers were not readily available, indicating the provider had failed to ensure robust systems were in place.
• We were not fully assured the provider was promoting safety through the layout and hygiene practices of the premises. We observed staff carrying out domestic tasks, however the house was not cleaned adequately. The kitchen had not had a deep clean for a significant time and there were dusty surfaces throughout the property. Staff told us they did not always have enough time to clean as they were focused on the safety and wellbeing of the people they supported.
• We were not fully assured the provider was using PPE effectively and safely. We saw two examples of face coverings being worn incorrectly which was not addressed by the management team. The remaining staff wore PPE correctly.
• Due to the above concerns, we were not fully assured the provider was making sure infection outbreaks were effectively prevented or managed. The provider promptly addressed these concerns after our inspection. However, the provider's audits and quality checks had not been used effectively to minimise risk from COVID-19. We have discussed this further in the well-led section of the report.
• We were assured the provider was meeting shielding and social distancing rules.
• We were assured the provider was admitting people safely to the service.
• We were assured the provider was accessing testing for people using the service and staff.
• We were assured 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.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

• There were systems in place to safeguard people. The provider investigated when there were concerns about a person and took action to keep them safe. However, in the last year they had not raised safeguarding concerns with the local authority, as required.
• We considered whether information might not have been shared because of a closed culture. We found this was not the case. During our inspection staff and managers were open and transparent. However, there was a lack of understanding about when to raise alerts with the local authority. Lack of effective provider oversight had failed to pick up where safeguarding alerts should have been raised.

• Following our inspection, the provider and local authority arranged a training session to ensure all senior staff were aware of their responsibilities. This represented a commitment to learning lessons when concerns were found.
• Staff were committed to keeping people safe from abuse. They told us they felt able to speak up and knew what to do if they had concerns about people's safety. Staff were involved in discussions with senior staff after incidents had taken place, where they reflected and learnt lessons about how to manage risk or respond in the future.

Staffing and recruitment
• There were usually the correct number of staff on shift. However, some shifts did not have enough experienced staff who knew how to support people safely. Staff told us this was because of high staff turnover. A member of staff said, "There are a lot of young staff, who don't have the skills and training."
• We observed a very new member of staff on their own in a communal area with people who presented a risk to themselves and others. Staff gave us examples where new colleagues had been asked to provide support when they did not have the required experience, training and confidence.
• Staff we spoke to gave this as a key reason for new staff leaving. A member of staff said, "The provider seems to think if you have enough staffing you are fine, but they do not have the skills. New staff are petrified and are leaving."
• Relatives told us how important it was to have staff who knew the people well. A relative said, "Staff who have known my family member longer get more results. They understand [Person's] communication, and how to judge their mood by facial expressions and tone of voice."
• We discussed our concerns with the area manager who described actions the provider was already taking to address retention. They had employed an officer to focus on retention and support new staff. They planned to move the manager's office to a more central position, which would increase support to staff. This assured us action was being taken to ensure people were supported by an experienced team who knew them well.
• There were safe recruitment systems in place.

Assessing risk, safety monitoring and management;
• Some people at Imola had complex needs which placed them and others around them at risk. The provider had the necessary expertise to offer a home within the community to people who might otherwise be living in a more restricted setting.
• Given people's complex needs, incidents occurred which placed people and staff at risk. This was particularly the case when new people moved to the service or a person's needs changed.
• Where people were supported by a skilled staff team who knew them well, risk was minimised, and people had an enhanced quality of life. Improved provider oversight was needed to ensure risks were consistently managed. The actions the provider was taking around staff retention were key to ensuring risks were managed safely.
• There were comprehensive risk assessments and detailed guidance to care staff with advice on how to minimise risk. Where required, people had positive behaviour plans to reduce risks to themselves and others. These were comprehensive and reviewed regularly. They included guidance on possible triggers which might indicate increased risk, such as a person's reaction to noise.
• The provider had worked hard to ensure guidance and care plans were accessible, with input from people and their representatives, including staff who knew them well.
• Relatives told us the service supported people safely. Two relatives described how they could tell their family member was safe from their body language and how well they related to staff.

Using medicines safely
• Prior to our visit we had a concern raised about a specific medicine error. We reviewed this incident and

found the provider had taken action as required, retraining a member of staff and carrying out observations to check their practice.
• Staff supported people safely and in a person-centred manner with their medicines, as outlined in their care plan. We observed a member of staff encouraging a person to take their medicines with a spoon of yogurt.
• The provider promoted a culture which minimised the use of medicine to manage people's behaviour, in line with current guidance. They had worked well with external professionals to consider how to minimise restrictions when a person was distressed, including whether taking certain medicines was in their best interest.
• Staff had the skills to support people with their medicines. They received regular training and competency assessments. There were effective checks to monitor whether people took their medicines safely.
• Medicine was stored in a lockable cabinet. The provider told us they were planning to improve storage arrangements for medicines, as part of an overall review of the layout of the property.

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; Working in partnership with others
• There were comprehensive systems to check quality and safety at the service, but they had failed to address some of the concerns we found at this inspection. The provider carried out monthly audits which highlighted gaps and tasks which the registered manager was working through. However, the tasks had not been prioritised effectively so risks to peoples' safety were not minimised.
• For instance, from March to June 2021, monthly audits highlighted the need to do a fire drill and a deep clean in the kitchen. A fire drill had not taken place since July 2020, despite new arrivals at the service and we observed the kitchen required a deep clean.
• Cleaning schedules were in place, but these were not properly maintained, which had not been picked up in the monthly audit or senior staffs' observation of the property. Quality checks had also failed to improve the infection control measures in place to welcome guests and poor PPE usage.
• The quality checks had failed to identify that the new registered manager had not sent safeguarding alerts to the local authority as required.
• Improved oversight was needed to ensure people were supported by staff who were able to minimise risk to their safety. Current staffing issues had resulted in inconsistent management of risk, as outlined in the safe section of this report.

The provider had failed to take action to effectively mitigate risk at the service and ensure the registered manager had an understanding of their regulatory requirements. This was a breach of regulation 17(2)(b) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Providers are required to notify the Care Quality Commission with specific information, such as when a safeguarding is raised. Historically, the provider had notified us of incidents and key information, as required. However, the last notification we had received from the service was March 2020, despite a number of incidents and safeguardings at the service. During our inspection, the new manager did not demonstrate a good understanding of when to contact us.
• The provider's monthly audits included reviewing whether notifications were sent to the Care Quality Commission as required. The failure to notify us had not been picked up by the provider. For instance, the audit for May 2021 listed incidents which had led to a person receiving injuries. These had been investigated and actions taken, however the provider had failed to alert us, in line with their statutory duties.

This failure to notify is a breach of Regulation 18 (Notifications of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

• After our inspection, the provider and registered manager sent us the missing notifications and put measures in place to ensure future notifications were sent as required.
• Professionals told us staff and managers at Imola communicated well with them around individual needs. We saw evidence in care records that professionals were fully involved and consulted about people's care. A professional told us, "I've had a good working relationship with Imola, they are always open to suggestions and work in the best interest of [Person]."
• Although the systems to manage risk at the service required improvement, individual risk as managed more effectively, through personalised assessments and high-quality care plans. However, these measures required an established and experienced staff team who had the ability to implement these systems.
• The management team described the challenges over the last year at Imola. In addition, to the impact of the COVID-19 pandemic, there had also been a change in management. Some staff told us the staff team was divided and did not always work well together. The provider had started to address staffing and retention concerns, however further time was needed to ensure these measures were making a positive difference at the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care;
• During our visit people spent a lot of time sitting in the lounge or walking round the house and patio. Feedback from some staff and families and review of records indicated people were not consistently engaged when at home. Improvements were needed to ensure all staff had the time and skills to support people to achieve good outcomes. Feedback was positive about people being able to spend time in the local community, such as going on drives or for a coffee.
• The management team described how they promoted person-centred, high quality care. They had recently held workshops for senior staff, including clinical, finance, maintenance and care management to ensure the values were shared across the organisation. These discussions on topics such as 'quality of life' and 'positive behaviour support' represented best practice.
• Documentation such as care plans and reviews, used positive and personalised language, reflecting a commitment to achieving good outcomes. Staff who knew people particularly well helped develop the plans and represent people's views. Agreed actions were practical and focused on people's wellbeing. For example, there was clear advice on how best to communicate with a person to minimise distress.
• The challenge was to ensure this positive practice and culture was implemented consistently across the service. Following the inspection, the provider told us they had decided to appoint a second deputy who would be responsible for supporting positive practice at Imola. This was a positive move to ensure people received consistently good care.
• Senior and care staff spoke with pride about what they had achieved since the last inspection, especially how they had worked together to support people during the COVID-19 pandemic. For example, staff had written social stories to help people understand why they could not see their families and why staff were wearing masks.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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
• Feedback from families was largely positive, in particular about the commitment of the staff team. One family member said, "I can't rate them enough. I couldn't be more happy with how hard they have worked. I have had concerns and the minute I raise them they sort it out."
• Relatives were consulted and involved in their family members care. They gave us examples where care

had improved after their feedback. Some relatives said formal reviews had been challenging during COVID-19 but this was starting to return to normal.
• Staffing feedback was mixed. They told us the management team were open and listened to them, however there was some frustration concerns were not dealt with effectively. Some staff told us the management team needed to take action to ensure people received consistently good care, irrespective of who was on shift.
• Staff concerns tended to be around the impact of staffing issues on safety and morale. Many of the staff we spoke to said they were exhausted with working long hours, and in challenging conditions.
• Despite the concerns staff were enthusiastic about providing high quality care and had positive relationships with the people they supported. Our observations and discussions with staff highlighted how committed they were to the wellbeing of the people they supported. A member of staff discussed some concerns but then said, "It's an amazing house. I am here because of the people who live here."

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify, in line with their statutory duties.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to take action to effectively mitigate risk at the service and ensure the registered manager had an understanding of their regulatory requirements.