Coveberry Limited

Eldertree Lodge

Inspection report

Elder Tree Lane
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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Eldertree Lodge is an independent hospital and as part of their registration with the Care Quality Commission they also operate a supported living service called Oakwood House. Oakwood House provides personal care to seven people with learning disabilities, autism and/or mental health needs, who want to live in the community. People living at Oakwood House have a tenancy agreement in place for their accommodation.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found

Risks to people's safety were assessed but the actions needed to keep people safe were not always present. Legal authorisations for the use of restricitve practice were missing and guidance was not always clear about what people could or could not do. This meant people were at risk of being unlawfully restricted. Accident and incident forms were not always reviewed although plans were underway to ensure this happened.

The provider did not carry out the necessary checks made to visitors, because of the COVID-19 pandemic, and staff did not always wear their face masks, as directed in the guidance.

The governance systems in place had not been effective at monitoring people's care. There had been a lack of oversight from the provider which meant a care plans had not been updated and some staff had felt forgotten. The provider acknowledged this and shared their action plan for making improvments and who was going to be responsible.

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.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.
Right support: Oakwood House was set up with the support of local commissioners and offers people bespoke packages of care in the community. However, amendments were needed to people's care plans to demonstrate how people were being enabled to have maximum choice and control over their lives.

Right care: People did have a personalised package of care. However, the provider was not yet able to demonstrate how they were ensuring people's human rights were maintained alongside a number of restrictive practices being in place.
Right culture: The service had recently gone through several changes, including a change of leadership. More time will be required to assess whether the leadership in place ensures people have 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 regulated activity of personal care being provided at Oakwood House is part of the registration of Eldertree Lodge. Eldertree Lodge has recently been inspected and is rated as Inadequate. Please see our website for the full report which is on the CQC website at www.cqc.org.uk

Why we inspected
This inspection was carried out following concerns raised at Eldertree Lodge. We undertook this targeted inspection to review how risk was being managed and the effectiveness of the governance systems in place. We also looked at infection prevention and control measures under the safe key question. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

CQC have introduced targeted inspections to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

Enforcement
Enforcement action has not been proposed for Oakwood House. However, enforcement action was taken following our inspection of Eldertree Lodge. Please see our website for the full report which is on our CQC website at www.cqc.org.uk

Follow up
We will continue to monitor information we receive about the service until we 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?

Inspected but not rated

We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question, we had specific concerns about.

We will assess all of the key question at the next comprehensive inspection.

Is the service well-led?

Inspected but not rated

We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

We will assess all of the key question at the next comprehensive inspection.

Eldertree Lodge

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to review the management of people's safety.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by three inspectors.

Service and service type
Oakwood House provides care and support to people living in seven 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The service did not have manager registered with the Care Quality Commission. The service was being managed by the provider's senior management team. A new manager for Oakwood House has recently been appointed.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service is small, and people are often out, and we wanted to be sure there would be people at home to speak with us.

What we did before the inspection
We reviewed all the information we had received about the service. The service had not been asked to complete a 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. We took this into consideration when reviewing our findings.

During the inspection
We spoke with all seven people who used the service and five relatives about their experience of the care provided. We spoke with 12 members of staff including the provider, deputy manager, senior care workers, care workers and members of the behaviour support team.

We reviewed a range of records. These included two people's care records, medicine records and accident and incident forms. We looked at a variety of records relating to the management of the service, including policies and procedures and on the second day of inspection we reviewed CCTV footage.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at Court of Protection documentation and training records. We also spoke with the multi-disciplinary team responsible for supporting people at the service.

Inspected but not rated

Is the service safe?

Our findings

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

Oakwood House is rated under Eldertree Lodge. At the last inspection for Eldertree Lodge this key question was rated as inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question, we had specific concerns about.

Assessing risk, safety monitoring and management
• People living at Oakwood House had legally authorised restrictions in place. However, the provider did not have copies available of the authorisations for staff to refer to, until after our inspection had commenced. This meant staff had been working for a period of time without being able to reference what restrictions were in place for people. This had the potential to put people at risk of experiencing unlawful restrictions.
• Some of the restrictions imposed upon people were not always clear. For example, when reading one person's care records we could not be sure when their flat door could and could not be locked. This put this person at risk of being in a locked environment when it was not necessary. We raised this with the provider and the multi-disciplinary team. We were advised following our inspection work had commenced to ensure the guidance was much clearer.
• Risk assessment reviews took place but action was not always taken to update the assessment when changes occurred. For example, several risk assessments referenced a staff alarm system which was not in operation. Instead staff used a radio system which was not referenced in any of the care files we looked at. This meant staff could not always be sure if the risk assessments were accurate.
• Accident and incident forms were not being reviewed on a regular basis by people working in the service. We were told that until recently incident reports, including restraint records were sent to Eldertree Lodge for review. However, we noted several incidents were still awaiting review. These included restraint records. This meant that the provider could not be assured that restraint being used was necessary and proportionate and any concerns about the use of restraint identified quickly. The provider's behaviour support team told us they had started to review the outstanding incidents alongside people's positive behaviour support plans to ensure they remained effective and in people's best interest.

Preventing and controlling infection
• We were somewhat assured that the provider was preventing visitors from catching and spreading infections. The provider had a process in place to record visitor's temperature and request additional information about their COVID-19 status. However, on our first visit to Oakwood House the process was not followed with several visitors.
• We were somewhat assured that the provider was using PPE effectively and safely. However, we observed instances on the CCTV where some staff were not always wearing their face mask properly. The provider offered us assurance that this would be taken seriously and PPE guidance followed.

We found no evidence that people had been harmed, however risks were not adequately assessed, and staff did not always have access to appropriate guidance to help keep people safe. 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.

• We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. People used shared kitchen facilities and the corridors were narrow. This meant people could not always avoid each other as they went about their day.
• We were assured that the provider was meeting shielding and social distancing rules.
• We were assured that the provider was admitting people safely to the service.
• We were assured that the provider was accessing testing for people using the service and staff.
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
• We were assured that the provider's infection prevention and control policy was up to date.
• We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

• People told us they felt safe living at Oakwood House and relatives were positive about the support people received. One person told us, "They manage me ok, some staff better than others but its ok here, much better than hospital." One relative told us, "I know [relative name] is safe, I see them every week and they are more settled at Oakwood House than anywhere else they have been."

Inspected but not rated

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.

The regulated activity of personal care at Oakwood House is inspected and rated under Eldertree Lodge. At the last inspection for Eldertree Lodge this key question was rated as inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question, we had specific concerns about.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• The governance systems the provider had in place had not been effective at monitoring the quality of care people received at Oakwood House. We found incident reports that had not been reviewed, missed signatures on medicine records which could not be explained, care plans needing updating and vital authorisations not accessible to the staff team. This meant the provider could not be assured that the care being delivered was safe and effective.

• Historically we were advised the staff team based at Eldertree Lodge maintained responsibility for reviewing the support people received at Oakwood House. However, we were advised by Oakwood House staff that Eldertree Lodge staff had rarely visited, especially in the past year, due to COVID-19. This had left the team at Oakwood House feeling quite isolated. One staff member told us, "Things have certainly got better but last year we definitely felt forgotten." The provider gave us reassurance that the team at Oakwood House would get the necessary support and closer monitoring would take place.

We found evidence that the governance systems in the service had not always been effective. This was a breach of regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider had produced an extensive action plan which they shared with us as part of the inspection. This highlighted areas where additional work was required and who was responsible. The plan included; ensuring the vision and goals for the service were clear, encouraging increased input of families and advocates and developing a service specific induction. The provider updated to their action plan following our visit and we will check on these improvements when we next visit the service.

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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not always up to date and staff did not always have access to information to ensure people remained safe.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were not always effective.