Action for Care Limited

Low Lane House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Low Lane House is a residential care home for up to six young adults who live with a learning disability and/or autism. At the time of inspection, six people were living at the service.

Low Lane House is a domestic property which was adapted to become a care home. People were supported across floors in the home.

People's experience of using this service and what we found
People were not safeguarded from the risks of abuse. Risk was not safely managed. Fire safety actions had not been addressed at the time of inspection. There were insufficient staff on duty to safely care for people. Medicine records did not support the safe administration of medicines. IPC guidance was not followed. The service needed cleaning throughout.

Quality assurance systems were not effective. They had identified some areas for improvement but not all. The overall quality of the service had significantly deteriorated since the last inspection. The registered manager did not have enough oversight of the service; they were no longer based at the service. Staff were supportive of each other and of the manager who was based at the service.

Staff were not effectively supported to carry out their roles. It was unclear how best practice guidance was used to care for people. The support people received for their mental health needed to be improved. The quality of the environment had not been maintained. People received good support with their physical health needs and their nutritional intake

People were not consistently 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 consistently 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 statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of safe, effective and well-led the service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. The model of service did not consistently support people's choice, control and independence. The way the service was used did not support safe care. People did have regular access to the community. People did not receive individualised care. Their privacy, dignity and human rights were not consistently maintained. The culture of the service did not lead to safe care for people and did not result in positive outcomes for them. We considered these

concerns when determining the enforcement and follow up action we needed to take.

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 13 August 2019).

Why we inspected
We received concerns in relation to staffing, training, incidents and management oversight. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

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.

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 inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe, effective 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.

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 dignity, the care of people, how people are safeguarded from abuse, the quality of the environment, staffing levels, training and induction and how the quality of the service is monitored.

During the inspection, we sent the provider a letter of serious concern which outlined the key areas of concern. They responded to this letter.

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 meet with the provider to review their action plan following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work 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 is therefore 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
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 well-led. Details are in our well-led findings below.	**Inadequate**

Low Lane 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.

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
Two inspectors and an Expert by Experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

One inspector visited the service on 24 and 28 June 2021. One inspector supported to review records related to inspection. An expert by experience carried out telephone calls to relatives.

Service and service type
Low Lane 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. 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 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 including the fire brigade and infection control team. 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.

During the inspection
We spoke with one person who used the service and five relatives about their experience of the care provided. We spoke with 15 members of staff including the nominated individual, an area director, two area managers, the registered manager, the new manager for Low Lane House, the deputy manager, two senior support workers and six support workers.

We also spoke with 14 health and social care professionals including GPs and nurses from one GP practice, an infection prevention and control nurse, a dentist, a social worker, mental health professionals, local authority commissioning teams for each person, a social care assessor and the fire service.

We reviewed a range of records. We reviewed three people's care records in full and aspects of three other people's records. We looked at four staff files in relation to recruitment and staff supervision. We reviewed the staff training matrix for all staff. We also reviewed a variety of records relating to the management of the service, including policies and procedures.

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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not always safeguarded from the risks of abuse. People were able to cause physical or emotional harm to other people whilst receiving one-to-one support from staff.
- When incidents took place, the needs of other people were not recognised. Training was out of date for some staff. There was a lack of understanding from some staff about when a safeguarding alert should be raised. Staff did have links with the local authority and did speak to them about potential safeguarding incidents.
- Restraint and restrictive practices were not always carried out in line with people's support plans. Alternative measures to de-escalate people's behaviours were not always tried first.

Failure to safeguard people from the risks of abuse had led to a breach of regulation 13 (Safeguarding service users from abuse) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- The risk of harm to people was not managed. Staff were not skilled in recognising risk or responding to risk. Behaviours could escalate quickly without appropriate action being taken or people could take items from communal areas to cause damage to the service or themselves.
- People did not receive effective support to manage their behaviours. The behaviour of people impacted on other people. Professionals raised concerns about these issues. There was a lack of appropriate support and oversight of people who needed one-to-one support. Support plans were not consistently followed. When restraint took place, other people were sometimes left without one-to-one support for short periods and their 1:1 support disrupted.
- Risks from the environment were not reviewed or acted upon. We asked the manager to take immediate action to address carpet grip rods which were on display in a communal area and to address safety concerns in one person's bathroom which they did.
- Actions in place from a fire authority visit in February 2021 were not addressed. A notification of deficiencies was issued following a visit from the fire authority in July 2021 which the provider had started to address.

There were gaps in fire safety and fire warden training. Gaps in staff completing a planned fire drill were addressed following inspection.

Failure to provide safe care to people has led to a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People's care was not always dignified. The immediate and consistent use of non-restrictive restraint

placing a hand on a person's arm and back is not dignified. Other person-centred approached were not used as an alternative means of de-escalation.
● Sufficient action was not always taken to have an appropriate skill mix of staff to provide safe and dignified care to people at night. Five staff expressed concerns about their own safety at night. A further two raised concerns about the safety of staff at night.
● When incidents took place, staff failed to support other people who were experiencing emotional distress as a result of those incidents. As a result of increased incidents, two people spent more time in their bedrooms. These incidents were being reviewed by the management team.

Failure to provide care in a dignified way has led to a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were not enough suitably trained and competent staff on duty to safely care for people. Staff and professionals raised concerns with us about this. An action plan was in place to address training.
● There were no 'floating' members of staff to relieve staff from providing one-to-one support during the day. There were not enough staff to carry out restraint safely. Staff needed to leave the people they were providing one-to-one support to, to support other staff with restraint.
● At night, there were not enough staff to assist people with personal care, to carry out restraint or to safely evacuate the building in the event of a fire. There were no responsive systems in place for staff to seek help from additional staffing at night when incidents occurred. One staff member said, "There isn't enough staff on nights." Another staff member said, "There is not enough staff during the night. [With some incidents] we need three to four staff at night."

Failure to have safe staffing levels in place has led to a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment was not carried out in line with the provider's recruitment policy. Records to support safe recruitment needed to be improved.
● Gaps in the employment history of the four records reviewed had not been explored. Risk assessments needed for two staff had not been completed to determine their suitability to work with vulnerable people.
● Gaps in employment records for some staff had been highlighted in a recent audit and action had started to be taken to address this."

Failure to have safe recruitment procedures in place has led to a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● A medicine for one person was not dispensed in-line with the guidance to administer it. This had gone unnoticed by staff. The person did not come to harm as a result of this. The staff member received additional support to improve their competency to dispense medicines. Quality monitoring of medicines needed to be improved. The provider updated medicines audits following inspection feedback
● Guidance for variable dose medicines was not in place. Staff decided how much of these medicines to give; no reasons were recorded for the decisions staff made about the quantity of medicine administered. Records to administer 'when required' medicines were insufficient or not in place at all. Action was taken to address these concerns following inspection feedback.
● A risk assessment was not in place for one person who managed one of their own medicines. This was not in line with a best interest decision in place for this person's medicines. No new best interest decision had

been completed to determine if this person was safe to administer their own medicine. A risk assessment was put in place following inspection.

Failure to have safe systems in place to administer medicines safely had led to a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were stored securely. Records were in place when medicine errors had occurred. Staff had been supported with supervision and training to improve their management of medicines.

Preventing and controlling infection
● The risks of cross infection were not understood or safely managed. Government guidance in relation to Covid-19 was not consistently followed. Training in preventing and controlling infection was not up to date.
● Staff were not bare below the elbow in-line with current government guidance. Sanitisation of hands and equipment was not carried out regularly where equipment was shared.
● The service required cleaning throughout. Regular cleaning of frequently touched areas was not in place. Staff did not have time to carry out cleaning duties because they were busy supporting people. Risk assessments for staff vulnerable to the risks of Covid-19 were not in place; these were put in place following inspection feedback.

Failure to manage the risks of cross infection has led to a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Lessons were not learned when incidents took place. The support provided by staff on a one-to-one basis did not prevent accidents and incidents taking place.
● Staff received injuries from people. There was no consistent reporting of these injuries; staff felt injuries were a part of the job. There was no alert system in place for staff to summon help if they were being assaulted.
● Analysis of accidents and injuries was limited and did not highlight any patterns and trends to allow the provider to understand where improvements could be made.

Failure to safely manage incidents taking place and demonstrate learning from them has led to a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 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 effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- 'Transforming care' guidance (aims to improve the lives of adults with a learning disability) was not considered when taking new admissions. Professionals raised concerns about the suitability of people living at the service. Some people's behaviours consistently impacted upon the well-being of other people.
- It was not always clear how best practice guidance was being used to deliver safe care to people. For example, there was a lack of evidence to demonstrate how staff were supporting one person with sensory deprivation needs. Best practice guidance for managing the risks of Covid-19 was not followed at the time of inspection. This was addressed following inspection feedback.
- Reviews of people's care were limited. They did not provide an accurate overview of the person and their needs to determine if any changes to their care were needed. Following inspection, the provider had arranged for a multi-disciplinary review of people's care.

Systems and records to support good governance did not demonstrate how people's care was holistically assessed and safely managed. This has led to a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Training was not up to date in many areas. The registered manager and manager had not completed their training. An action plan was in place for staff to complete their training. Professionals and a relative, raised concerns about the competency of staff to deliver the right care to people.
- Staff did not receive an induction in-line with the provider's policy. The manager and deputy manager had not received an induction. Staff records did not show if staff were successful during their induction period or if additional support was required. Not all staff completed the 'Care certificate' (an agreed set of standards) during their induction as specified in the provider's policy.

Failure to support staff to carry out their roles safely and to deliver safe care to people has led to a breach of regulation 18 (Staffing) 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 systems in place at the service did not support people with their mental health needs. Staffing levels, training, record keeping, and quality monitoring systems impacted on this.
- Mental health professionals said they were not always involved when people moved into the service to

allow them to monitor their transition and offer appropriate support. They had offered training to support staff to deliver the right care for people's mental health needs. In addition, they had planned to carry out assessments to provided individualised mental health support to people.

Failure to have consistent and timely care in place for people has led to a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were supported with their physical healthcare needs. Staff worked creatively to support people to access healthcare. Referrals for support were completed and people had good access to professionals such as GPs and dentists. A GP practice provided collective feedback and said, "Staff were receptive to improved ways of working and people's agreed plans of care were followed.
● Positive feedback from a dentist was received. They said "Staff were helpful and engaging with people's needs at the top of the list of priorities. Risk [of accessing and receiving treatment] was appropriately considered.

Adapting service, design, decoration to meet people's needs
● Improvements were needed throughout the environment. A limited improvement plan was in place which did not include timescales or have any planned works in place.
● Walls and paintwork were worn, stained or damaged. There was significant damage to one person's bedroom which had not been addressed. Staff had raised concerns about the environment and about the timeliness and quality of improvements

Failure to maintain the premises has led to a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were involved in decision making about the environment. For example, people were involved in making decisions about how rooms should be decorated and what colours wall should be. One person was recently given samples of flooring to make their own choice about the flooring in their en-suite.

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).

We checked whether the service was working within the principles of the MCA.

● There was a lack of understanding about the Mental Capacity Act 2005 (MCA). Best interest decisions were not consistently recorded. There were gaps in training for MCA. The provider had identified training in this area needed to be completed and had booked in dates for staff."
● Staff successfully co-ordinated a best interests meeting for one person needing health care from various health professionals. This led to the person receiving timely healthcare. Both the person and their relative had been involved in this decision making.

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

● People were supported with their nutritional intake. Care and support was delivered in-line with recommendations from health professionals. Referrals for support with nutrition has been made when needed.

● People's meals were centred around their choices, likes and dislikes. "Two relatives provided positive feedback about people's nutritional intake. One relative said the support staff had given one person had a positive impact on their health condition. Another relative said, "Staff keeping trying [person] with new tastes and their diet is constantly expanding."

● People who wanted to be, were involved in shopping, preparing and cooking of food. Cupboards were well-stocked. People had access to regular drinks and snacks.

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 good. 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.

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

- The systems in place did not consistently support people to achieve good outcomes. The culture of the service impacted upon the well-being, dignity and risks to people and staff. Limited resources were in place to safely manage the risk of harm to people and staff.
- Insufficient support was in place for staff. They worked in a challenging environment and were continually dealing with risk. Staff were clearly struggling and at risk of 'burnout.'

Failure to deliver good outcomes to people has led to a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff maintain links with people's relatives. Staff had spoken to relatives on the telephone to provide updates to them. People received visits and arranged to spend time with their families once Covid-19 restrictions had been lifted.
- The staff team were open and transparent during inspection. They were supportive of each other. They did try to work as a team and tried to problem solve when incidents took place. They spoke positively about the manager. One staff member said, [The new] "Manager is fantastic." Another staff member said, "The [new] manager is spot on. She is so understanding."

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; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Quality monitoring systems were ineffective. Audits had identified gaps with record keeping, training and insufficient policies. However, they had not identified issues surrounding the care of people. There were gaps in audits which limited their effectiveness.
- The quality of record keeping in all aspects of the service needed to be improved. A lack of accurate and consistent reporting of incidents had not allowed the provider to have a clear picture of the number and type incidents taking place. Processes to ensure lessons were learned were not in place.
- The registered manager was no longer based at the service. There was a lack of evidence to show how they had oversight of the service and how they were supporting the new manager to deliver safe care to people. Relatives and staff told us the registered manager no longer worked at the service. An area manager for the provider was involved with the service.

Failure to have effective governance systems in place has led to a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service was going through a transitionary period with a new manager, deputy manager and senior support workers. The manager acknowledged this had impacted upon existing staff and people using the service. The new manager was supported by an area manager. During inspection feedback was addressed. The manager understood further improvements were needed and were working with the senior leadership team to do this.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Staff sought assistance from professionals when needed. There were mixed reviews from professionals about the quality and timeliness of information shared with them.

● The service had received positive feedback from relatives. Surveys had been completed but not analysed. Analysis of staff surveys had been completed. This demonstrated staff had confidence in the service, the care provided and oversight by the provider.

● The service had good links with the community. People visited a local swimming pool, a local pub and local shops. People interacted with their neighbours and received Christmas cards from them.

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 10 HSCA RA Regulations 2014 Dignity and respect (1) People's dignity was not consistently maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment (1) People did not receive safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment (1) People were not safeguarded from the risks of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment (1) The quality of the environment had not been maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing (1) (2) There were insufficient staff on duty to safely care for people. Staff were not sufficiently trained or supported to carry out

their role.

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 12 HSCA RA Regulations 2014 Safe care and treatment (1) (2) (h) Safe infection prevention and control measures were not in place.

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance (1) Systems in place to monitor the quality of the service were not effective.

The enforcement action we took:

We issued a warning notice.