

Peninsula Autism Services & Support Limited

Coolhaze

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

Coolhaze is a residential care home providing personal care and accommodation for up to three people. Coolhaze provides care for people with a learning disability and associated conditions such as autism. Accommodation is arranged over three floors with each person having their own self-contained flats. At the time of the inspection three people were living at the home.

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

Not everyone living at Coolhaze was able to share their views with us. One person told us they felt safe at the service and trusted the staff: they said the service was "really good". Another person we met looked happy and relaxed in staff's company.

We found improvements were required in how the safety and quality of the service is assessed, monitored and improved. Care records were not always fully accurate, and the safety checks and maintenance of the equipment and grounds was insufficient to ensure people and staff were safe. The provider's quality assurance and governance systems had not been effectively implemented and improvements were made only after the commencement of the local authority's safeguarding investigation.

We also found people were not always provided with care and support that was person-centred. We made a recommendation to improve how people are supported to develop their skills and engage in activities meaningful to them.

Medicines were being managed safely, after action had been taken following a medicine error.

We received positive feedback from four staff: all reported feeling well supported by the registered manager, and they said they enjoyed working at Coolhaze.

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 (report published 16 July 2018)

Why we inspected

We received concerns in relation to people's safety and well-being. 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 improvements. Please see the safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Coolhaze on our website at www.cqc.org.uk.

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 a breach of regulation in relation to managing risks to people's health, safety and welfare, as well as with the implementation of effective governance systems at this inspection.

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 ●

Coolhaze

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 also looked at the infection control and prevention measures in place. This was conducted as part of our Thematic Review of infection control and prevention in care homes.

Prior to this inspection we received information of concern in relation to safe care and support. We shared this information with the local authority who commenced a safeguarding investigation which had not yet concluded at the time of writing this report.

Inspection team

One inspector undertook this inspection.

Service and service type

Coolhaze 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

We gave the service 24 hours' notice of the inspection. This was because Coolhaze is a service for people with autism, and we wished to provide notice to support people's understanding of the inspection.

What we did before inspection

We reviewed information we had received about the service since the last inspection. This included

information from the local authority's safeguarding and quality improvement teams, as well as health and social care professionals who work with the service. We also reviewed the information the service is obliged to provide us with, such as accidents where people sustained an injury. We used all of this information to plan our inspection.

We had not requested the provider send us 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.

During the inspection

We met with two people who used the service; speaking with one in detail about their experience of the care provided. We spoke with two members of staff, registered manager, provider's operational manager and quality assurance and improvement lead officer.

We reviewed a range of records. This included one person's medication records, three staff recruitment files and a variety of records relating to the management of the service.

After the inspection

We reviewed the care records for all three people and continued to seek clarification from the registered manager to validate evidence found. We looked at training data, quality assurance records and a number of policies and procedures. We spoke with a professional who had visited the service recently. We contacted all staff employed at the service to invite them to participate in the inspection: we received positive feedback from four staff.

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.

Prior to this inspection we received information that people were not receiving safe care and treatment. We considered this information when undertaking our inspection.

Assessing risk, safety monitoring and management

- People were not always protected from risks associated with their care needs. Assessments identified risks, for example, in relation to diabetes management, mobility, skin care and the risk of choking. Management plans guided staff to support people in a way that mitigated risks, however records used to support risk management were not always accurate.
- For example, we found records used to support the monitoring of one person's diabetes were not always accurately completed. The person's care plan stated, "Staff supporting [name] to complete Daily Food Intake Logs with accurate information of his food and fluid intake." However, we found their food intake record did not include all the food they had eaten. The person's daily care records showed they were having supper prior to going to bed, however this was not always included in their food intake records. This meant the information upon which judgements were being made about how well their health condition was being managed was inaccurate. This could place the person at risk as healthcare professionals used this information to make judgements about health interventions. The person had recently had their diabetes medicine increased due to raised blood glucose levels which meant accurate records were essential for making safe decisions about their treatment.
- We found improvements were also required with how the service managed the safety of the environment. In the service's internal quality audit dated 6 August 2020, the operations manager identified action was required in relation to fire safety and portable electrical appliance testing (PAT). They identified fire safety checks had not been carried out as they should have been in line with the government's fire safety regulations, and that PAT was out of date. This meant the service could not be sure the fire alarm system and firefighting equipment, and the electrical equipment used by people and staff, were functioning safely.
- They also identified the pathways leading to the entrance of the service as well as people's individual garden areas had not been maintained and were not easily or safely accessible for people.

Failure to mitigate risks to people's health, safety and welfare is a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activity) Regulations 2014.

- The service had acted to address the safety of the premises and equipment, as well as the routine maintenance of the building, prior to our visit. However, this action had been taken after the local authority's safeguarding team had visited the service and had not been initiated through the service's own

earlier safety audits, particularly that dated 9 July 2020.

- One person told how well they were being supported and described the staff as "really good". They said they trusted staff to support them, particularly when anxious. We saw this person was being guided about managing their health and weight, and records showed they had successfully lost 9.5 kgs over a nine-month period.

Staffing and recruitment

- Many of the staff were new to the service and as such had not undertaken all the required training relating to people's care needs. For example, not all staff had undertaken training in the management of diabetes, caring for people living with epilepsy and positive behavioural support. These are important training subjects which support the staff's understanding of people's complex needs. The registered manager confirmed this training had been arranged and showed us confirmation of this.
- Recruitment practices remained safe with pre-employment checks, including disclosure and barring (police) checks, carried out by the provider's human resource team prior to the commencement of employment.
- People were included in the interviewing of staff and their views about their suitability to work at the service were listened to. The registered manager told us one person had recently chosen two members of staff to join the care team.
- The service was actively recruiting to ensure they had sufficient staff available. The duty rota showed the service was using agency staff as well as overtime to cover shortfalls, some of which resulted from a temporary increase in one person's staffing support overnight.
- The operations director reported that all staff hours were reviewed to ensure no staff was working excessive hours, and that the senior management team understood staffing requirements.

Using medicines safely

- The service was managing people's medicines safely. In May 2020 the registered manager acted to review the safety of the service's medicine practices following a medication error. This had resulted in a period of time when not all staff working overnight were permitted to administer medicines. No routine medicines, or those to be given in an emergency were prescribed overnight. The registered manager told us that should any pain-relieving medicines be required during the night, staff would contact them, and they would come into the service to administer people's medicines.
- Records showed all staff had now received training in the safe administration of medicines and the registered manager confirmed they had reviewed their competency.
- Where people took medicines 'as and when required', staff were provided with guidance about when this should be administered.
- There were safe arrangements to receive, store and dispose of medicines.

Systems and processes to safeguard people from the risk of abuse

- Staff told us, and records showed, they had received training in safeguarding adults. Information about safeguarding, whistle-blowing and the employee assistance programme (independent from the service and provider) was provided to staff with information about their obligations to protect people from abuse. The service's vision and values were incorporated in these policies, and staff were instructed that poor care and support would not be tolerated. The registered manager said these values were discussed at team meetings, through supervisions and at the service's recent staff well-being day held in May 2020.
- One person told us they felt safe living at Coolhaze. Another person was unable to share their views with us, but they looked relaxed in staff company and approached staff freely. This indicated they felt safe with the staff supporting them.

Preventing and controlling infection

As part of CQC's response to the coronavirus pandemic we are conducting a thematic review of infection control and prevention measures in care homes, and we included the review in this inspection.

- The service was reducing the risk of visitors catching and spreading infections. Handwashing facilities and hand gel were available at the entrance to the service and to people's own accommodation. Visitors were asked to complete a checklist in relation to their health as well as any potential exposure to Coronavirus. Visitors were requested to wear masks which were provided.
- Staff and people living at the service were participating in routine testing.
- Staff were seen to wear personal protective equipment, such as gloves, aprons and masks. The registered manager confirmed that for some people the wearing of aprons and gloves would cause distress and anxiety, and as those people did not require support with personal care, these were not routinely worn. We asked the registered manager to ensure the rationale and risk assessment for this was recorded and shared with the local authority.
- The provider's infection prevention and control policy was up to date and guidance was available to staff.

Learning lessons when things go wrong

- Reflective practice and debriefing sessions were used by the service to review and analyse incidents and accidents to develop future learning.
- The registered manager, operations director and quality assurance lead recognised that some processes used to ensure people received safe care and treatment had not been effectively implemented. Action had been taken to address this.

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; Continuous learning and improving care

- We found the provider had well-established quality assurance and governance systems. However, failure to effectively implement these had led to a decline in the quality and safety of the service, and people had been placed at risk.
- The service's own internal audit dated 9 July 2020 failed to recognise unsafe practice or to provide robust evidence that people's care needs and support plans had been reviewed. The audit had been undertaken by a senior manager and signed as accurate by the registered manager.
- The following month's audit, dated 6 August 2020, undertaken by another senior manager after the commencement of the local authority's safeguarding investigation, identified a number of areas for improvement. For example, in July 2020 the audit recorded the fire safety system was being routinely checked: in the audit in August 2020, it was identified the fire safety system had not been routinely checked since March 2020.
- In addition, the August 2020 audit identified the care records for the most recently admitted person were "very limited" and that further information was required in relation to care planning, risk assessment, mental capacity and positive behavioural support. The July 2020 audit had not identified this: there was just a 'tick' to indicate a review.
- This meant the reliability of the internal audits to identify and make improvement to the safety and quality of the service could not be assured. While action had been taken to address these shortfalls, this occurred only after the commencement of the safeguarding investigation by the local authority.

The failure to have effective systems and processes in place to assess, monitor and improve the service is a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People lived in their own self-contained accommodation and were reliant upon staff support to develop their daily living skills and be involved in meaningful activities. However, we found people were not always provided with care and support that was person-centred.
- Care records described what was important to people and goals were planned for the forthcoming month. However, it was not possible to ascertain whether these identified goals had been achieved. Monthly reviews between people and their keyworker did not describe what activities people had undertaken or achieved

since the previous review.

- Also, people were not always supported to engage in activities that were meaningful to them since the imposition of social restrictions to control the spread of Coronavirus. For example, one person's care records stated how much they enjoyed gardening, and prior to the imposition of restrictions, attended an allotment. However, since not being able to attend the allotment, the service had not used the person's own private garden and patio area to replace this activity. We found their garden area to be completely empty with the exception of a bench table. Staff had not attempted to support the person with their interest in gardening, such as growing flowers or vegetables. Shortly before this inspection, the garden areas had been overgrown and unusable. This meant people had not been able to access any outside space within which to sit and enjoy being out of doors.

We recommend the service reviews its processes to ensure the delivery of high-quality care and support, which promotes a positive, person-centred culture and achieves good outcomes for people.

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 and senior management team had taken seriously the information of concern shared with us and the local authority. They had examined their processes and taken action where they had found improvements were required. The registered manager and operations manager had worked cooperatively throughout the inspection.
- The registered manager reported the service had a good relationship with people's relatives and kept them up to date with information as appropriate.

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

- During and following the inspection we received positive feedback from staff and one person living at the service. The person we spoke with told us, "Coolhaze is good and it is fun."
- Staff told us they were being well supported by the registered manager, and that training and supervision were well managed. One member of staff said, "If I need assistance from the manager, day and night she is always on the end of the phone to assist myself in any way possible." Another said, "My time at Coolhaze has been amazing, I've progressed so much since being at Coolhaze, my relationship with [service user's name] is incredible and my manager has helped me progress with starting my Adult NVQ. There's so much positivity there, there's honestly not a bad word I could say, the management, support team and the service users are just incredible."
- Records showed the service maintained contact with some healthcare professionals, including GPs, community nurses, as well as those involved in commissioning and reviewing the service. However, not all professionals involved with reviewing and supporting people's care and treatment found the service was responsive to requests for information. The operations director had taken action following the inspection to address this. They had also provided the local authority with an action plan to address the shortfalls identified through the inspection and safeguarding processes.
- Records showed staff had undertaken training in relation to equality and diversity. The service's principles, reflected in their policies and procedures, promoted non-discriminatory support.

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider failed to maintain accurate, complete and contemporaneous records in relation to people's care and treatment.</p> <p>The provider failed to properly assess, monitor and improve the quality and safety of the service through its governance processes.</p>