CareTech Community Services Limited

CareTech Community Services Limited - 19 Wheelwright Road

Inspection report

19 Wheelwright Road
Erdington
Birmingham
West Midlands
B24 8PA

Tel: 01213504383

Date of inspection visit:
24 August 2020
25 August 2020

Date of publication:
21 October 2020

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
CareTech Community Services Limited- 19 Wheelwright Road is a residential care home providing care to six people who are living with a learning disability or autism at the time of the inspection.

The care home accommodates six people in one adapted building. Two people have their own flats and the four other people share communal living areas. The service has been designed taking into account best practice guidance and the principles and values underpinning Registering the Right Support (RRS) in respect of the environment. The building design was similar to other homes in the residential area and was in keeping with other homes in the street. There were deliberately no identifying signs, cameras, industrial bins or anything else outside to indicate it was a care home.

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

People received safe support with their medicines. There had been improvement in safeguarding systems and in systems around supporting people with behaviours that challenge. Further improvement was needed to ensure these became fully effective and embedded into practice. There were sufficient staff available to support people safely.

There had been some improvements made to the provider's governance systems. However, we found that systems had not been consistently effective in identifying some of the areas for improvement that we found at the inspection. Further improvement was needed to ensure the systems were fully effective and embedded into practice.

Staff reported a positive change in the culture of the service and the positive effect this had had for people living at the home.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement overall and inadequate in well led (published 2 July 2020). We identified multiple breaches of regulation.

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found enough improvement had been made in some of the areas of concern we had previously identified, and the provider was no longer in breach of two regulations relating to safeguarding and safe care and treatment. However, enough improvement had not been sustained in the monitoring of the service and the provider remains in breach of this regulation (Regulation 17, Good Governance).

The last rating for this service was requires improvement (published 2 July 2020). Following this inspection the service remains rated requires improvement. Whilst the service had previously been rated Good in February 2019, the last two inspections have rated the service as requires improvement.

Why we inspected
There were significant concerns raised around the culture and safety of the service at the last inspection. Whilst we had received assurance that improvements were in progress a decision was made for us to inspect to assess the culture of the service and to assess the improvements we had been informed about. The ratings from the previous comprehensive inspection for the other key questions not inspected were used in calculating the overall rating at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for CareTech Community Services Limited- 19 Wheelwright Road on our website at www.cqc.org.uk.

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?

Requires Improvement

The service was not always safe.

Details are in our Safe findings below.

Is the service well-led?

Requires Improvement

The service was not always Well- Led.

Details are in our Well-Led findings below.

CareTech Community Services Limited - 19 Wheelwright Road

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 as part of our Thematic Review of infection control and prevention in care homes.

Inspection team
The inspection was carried out by two inspectors who carried out the site visit on 24 August 2020. On the 25 August 2020 one inspector made phone calls to staff and relatives and one inspector reviewed documentation sent to us as part of the inspection.

Service and service type
CareTech Community Services Limited- 19 Wheelwright Road is a 'care home'. People in care homes receive accommodation and 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 does not currently have a registered manager. The previous registered manager had left the service following our last inspection. An interim manager had been providing managerial cover at the service since March 2020 and stated their intentions of applying to become registered with us. Registered managers 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 a short period of notice of the inspection because of the risks associated with Covid 19 and to make sure everyone could remain safe during our inspection site visit.

What we did before the 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 people at the service. We reviewed action plans that had been sent following our last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection
We met five of the people who lived at the home and spoke with two people who used the service about their experiences of the care provided. We spoke with six members of staff including the manager and four staff members.

We reviewed a range of records. This included two people's medication records, incident and accident records and quality audits carried out by the provider.

After the inspection
Following the site visit we reviewed further records including sampling three peoples care plans and risk assessments, policies and procedures, a training matrix and minutes of meeting held within the home. We spoke with the managing director and the operations director and one further staff member for their views of the service.

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 requires improvement. At this inspection this key question has now remained the same. 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.

Systems and processes to safeguard people from the risk of abuse
At our last inspection the provider had failed to ensure effective and robust systems were in place to safeguard people. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

- Following our last inspection safeguarding incidents had been reported to relevant authorities in a timely manner.
- Staff we spoke with were aware of the signs of abuse and felt able to report any safeguarding concerns. One staff member told us the manager was, "Very good, [I] can raise concerns."
- One person we spoke with told us they were happy living at the home and said, "I like to live here. I like the people they look after me."
- The majority of staff had received training in safeguarding and this topic had been reiterated with staff during staff meetings and supervisions following our last inspection.

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

At our last inspection the provider had failed to mitigate risks to the safety and welfare of people when people used behaviour and self- harm as a means of communication. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

- Following our last inspection, work had been carried out in-conjunction with the provider's behaviour support team to review and improve the plans to support people with behaviours that may challenge.
- Staff were aware of these positive behaviour support plans (PBS) and could tell us how they used them when people were displaying behaviours that challenge. One staff member told us that prior to our last inspection they didn't know there were PBS plans available and said, "I didn't even know there was one but [behaviour team] gave extra Maybo [training] and the PBS is person centred. If you did have to work with [person] you could." Maybo is a training method that teaches how to reduce the risk of behaviours of concern and workplace violence.

● A staff member told us of the benefits of the additional work that had been carried out around PBS for people who lived at the home and told us, "Staff now know how to support [person] and they are happier. They still have challenges but much less incidents."
● Staff were able to tell us what action to take should a person injure themselves when displaying behaviours that challenge. Upon reviewing incident records, we saw that in most cases medical advice had been sought promptly when needed. However, we found one incident had a delay of overnight before medical advice was sought. Whilst the new systems in place had highlighted this to enable medical advice to be sought for the person, this indicated that these systems needed embedding further to ensure action was taken promptly all the time.
● Following our last inspection, the provider had carried out work to ensure there were more detailed records when incidents of behaviour occurred. Due to the increased detail available about incidents the manager had been able to take learning from the incidents and put things in place to reduce the chance of reoccurrence. The analysis of incidents was also occurring more frequently.
● Whilst we saw that action plans were in place following the analysis of incidents further improvement was needed to ensure these became fully effective. For example, where a lesson had been learnt to reduce the chance of reoccurrence there was no follow up action planned to see if this had been effective and or worked in practice. In addition, there was no system in place to analyse incidents at a service level. This could help the manager identify further trends which in turn would further reduce the chance of a similar incident occurring again.
● Training had taken place relating to Maybo which is a training method that teaches how to reduce the risk of behaviours of concern. One staff member told us this training had been tailored to the people living at the home to enable the training to be more specific to people's needs.
● Staff were aware of the risks associated with people's care and could describe how to support people with behaviours that challenge. All the staff we spoke with told us that restraint would be used as a last resort and that other techniques would be used to de-escalate the situation first.
● Whilst we saw people's care plans described the risks associated with their care, we saw some discrepancies between the care plans and PBS which may of caused an inconsistency in approach when supporting a person. We have raised this with the provider.

Staffing and recruitment
● Most of the people living at the home had a staff member allocated to support just them for the majority of the day. We saw that people were receiving this level of support during the inspection visit.
● The provider had developed a contingency plan for staffing due to the Covid- 19 pandemic which had determined safe minimum levels of staffing. One staff member told us that staffing levels had reduced to this minimum level but on rare occasions. The manager informed us that recruitment was underway.
● At our last inspection we had identified that recruitment practices were safe. No new staff had started working at the service since our last inspection.

Using medicines safely
● Only staff who had received training in medicines were able to administer medicines to people. A staff member described how medicines processes had changed to make them more effective including making one staff member accountable for giving medicines on each shift.
● A review of medicines records demonstrated that people's daily medicines were given safely. We noted that two protocols for 'as required' medicines were not in place and one protocol stated incorrect dosage information. These were put in place by the end of the inspection.

Preventing and controlling infection
● The home was clean and clear from clutter. Following our last inspection there had been a number of

noted improvements to the environment of the home and it looked more homely.

● Staff had received training around infection control and could tell us how they were following guidance around the use of personal protective equipment (PPE) in practice, such as wearing aprons and gloves, and additional cleaning that was taking place.

● We saw there was information available for visitors around the signs of Covid-19 and guidance on handwashing techniques. We also saw hand sanitiser available and a reminder for staff to use this.

● Whilst there were many areas of good infection control practice, we found some areas that could be improved further. For example, some staff had refused testing for Covid-19. There had been no risk assessment put in place around this, although this was completed by the end of the inspection. In addition, there was one person who needed staff to remove their masks to enable communication to take place. Whilst a number of control measures were in place further consideration was needed to ensure this practice was fully safe for staff and the person.

● Whilst we saw that infection control audits were in place, they had not been amended to include the specific considerations of infection control associated with Covid-19.

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 Inadequate. At this inspection this key question has now improved 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.

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

● At our last inspection we had identified concerns with the culture of the service and staff had described a culture that was not open or transparent. At this inspection staff reported a change in the culture to a more positive and inclusive one with one staff member saying the service had, "Drastically changed." Another staff member spoke about the manager and said, "Nothing is off limits she makes things happen." Another staff member told us about the changes in the service and said, "The service users are much happier."

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

At our last inspection the provider had failed to implement robust governance systems. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst we noted improvement, insufficient improvement had been sustained or embedded to meet this breach of regulation and the provider remains in breach of regulation 17.

● The provider's systems had not always been effective in identifying where documentation was missing or incomplete. For example, a medicines audit carried out had not been effective in identifying that PRN protocols were missing from two peoples medicine files and one PRN protocol had incorrect information present.

● Systems had not identified further improvements that were needed around the use of PPE and Covid-19 testing.

● Systems to monitor the safety of the home were not always effective in highlighting areas of concern. For example, we saw that water checks were carried out. Where the optimum temperature range was not met there had been no consistency of escalation to resolve these matters.

● Systems had not identified that information present in care plans and PBS was on occasion conflicting. This meant that people may receive inconsistent support with their care.

●The manager had reviewed documentation and identified actions that needed to be taken. This included incident forms and environmental checks such as fire safety and water checks. Where there had been a follow up action identified, there was no time scale for achieving these actions and no sign off when actions had been completed. Whilst the manager was able to tell us some actions that had been taken it wasn't always evident if required actions had been achieved.

These issues constitute a continued breach of Regulation 17.

●Following our last inspection, the provider had ensured quality monitoring visits were carried out more frequently to retain oversight of the planned improvements needed in the service.
● At our last inspection we found that the provider hadn't identified that staff were not having regular supervision. At this inspection we found that this was now occurring. A system had been devised where planned supervisions were taking place. Staff we spoke with felt more supported than previously and one staff member said, "We do have our supervisions and anything we need help with."
● The previous registered manager had left the service shortly after our last inspection. The current manager had started working at the service in March 2020 and stated their intention of applying to become the registered manager. The managing director had ensured oversight of the service remained during these managerial changes.
● The manager told us, "We have been working hard and still things to do but have worked really hard to get to where we are."

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
● We have had continued correspondence with representatives of the provider following our last inspection. Both have shown openness and transparency throughout and have shown a keen desire to make improvements at the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● At this inspection we found that people had begun to have involvement in the service through meetings and surveys.
● Further work was needed to ensure these became fully effective. For example, where people raised questions or identified changes they wished to occur, there was no action plan of how and by when this would be completed by.
● People had been involved in the changes that had been made to the environment of the home. Both staff and people living at the home commented that they had been beneficial. One staff member told us, "The service users feel like it's their home…. They've never had it nice before so it's good."
● Staff told us that they now felt more involved in the running of the service and one staff member said, "Things make more sense, more structure and routines so service users are happier."
● Whilst Covid-19 restrictions were in place the service informed us that they had enabled people to stay in touch with their family members through phone calls, video calls and garden visits.

Working in partnership with others
● The service had altered their means of communicating with other professionals through the Covid-19 pandemic. Most communication now took place via telephone calls. People were still able to access the healthcare if needed, to meet their individual needs.

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 17 HSCA RA Regulations 2014 Good governance The provider had not made sustained improvements in the governance systems at the service.