Camino Healthcare Limited

Vestige Healthcare (Nuneaton)

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

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

Summary of findings

Overall summary

About the service
Vestige Healthcare (Nuneaton) is a residential care home providing accommodation and personal care for 15 children and younger adults with learning disabilities and/or autism spectrum disorder. The service can support up to 20 people.

People's experience of using this service and what we found
The providers systems and processes did not always ensure risks to people were known and people remained safe. While people received their medicines as they were prescribed, medicines were not always stored and managed in a safe way. Staff were recruited safely, however the provider relied on a significant number of agency staff. Infection control was well managed, and the provider ensured staff followed current government guidelines.

The providers systems to monitor the quality and safety of the service were not always effective and had not identified all areas for improvement. The providers systems had not identified the concerns that may arise with children and adults sharing the same space. The provider did not always communicate effectively with families and other professionals involved in peoples care.

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

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 guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Rating at last inspection and update
This service was registered with us on 28 June 2011 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding, use of restraint and the care being provided. Additional concerns were shared with us by the Warwickshire Clinical Commissioning Group and Warwickshire Local Authority. A decision was made for us to inspect and examine those risks.

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 coronavirus 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.

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

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

Enforcement
We are mindful of the impact of the COVID19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID19 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 person centred care, safeguarding, recruitment practices and governance.

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 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?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Vestige Healthcare (Nuneaton)

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The inspection was carried out by two inspectors, one children's inspector and one mental health act reviewer. One inspector, one children's inspector and one mental health act reviewer visited the home on the 24 September 2020. Two inspectors visited the home on 01 October 2020 for a second day of inspection. Three Inspectors undertook telephone calls to staff, relatives and professionals on 29 and 30 September 2020.

Service and service type
Vestige Healthcare (Nuneaton) 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 did not have a manager registered with the Care Quality Commission.

Notice of inspection
We gave a short notice period of the inspection because of the risks associated with COVID19. This meant

that we could discuss how to ensure everyone remained safe during the inspection.

What we did before inspection
We reviewed information we had received about the service. We sought feedback from the local authority and clinical commissioning group who work with the service. 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 spoke with two adults and three children that lived in the service. We spoke with four relatives about their experience of the care provided to their family members. We spoke with five members of staff, the manager, the chief operating officer and the nominated individual. We also spoke with two healthcare professionals involved in peoples care.

We reviewed a range of records. This included three people's care records, restraint records and medication records. We looked at one staff file in relation to recruitment. We also looked at records that related to the management and quality assurance of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated 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.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- The provider had failed to ensure people who were at risk of self-harm were kept safe. Items which could be used to self-harm were accessible to people in the home. Risk assessments failed to provide staff with the information required to keep people safe from harm.
- Handover records we reviewed showed people were placed on varying periods of observation each shift in order to manage risk. Decisions to change levels of supervision were made by differing nurses in charge of shifts, this could include an agency member of staff. There was no clear definitive rationale or process in place to guide these changes which left people at risk of harm.
- We found the information handed over between shifts had not always included all the people receiving the service. This meant that people were at risk due to a changeover of staff and them not knowing the current risks.
- We found the behaviour displayed by people was not consistently recorded in all the daily records staff completed. We saw gaps in people's daily notes where staff had failed to complete their records for days at a time. A lack of detailed, up to date and accurate records meant there was a risk that all staff would fail to know of these behaviours, the resulting risks or how to mitigate against them to keep people safe.
- We saw in people's daily notes details of incidents that had happened. However incident reports were not always completed by staff for all incidents that happened. This meant the extent of people's behaviours and how they were managed were not always known and lessons were not always learned which placed people at risk of harm and abuse.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- While family members told us, they were impressed by the facilities they had concerns over the providers risk based approach. One family member told us, "I am on the fence about [person's] safety. Vestige has to tread a very fine line from what they want to offer and safety." Another said, "I would expect the self-harm to decrease, it hasn't."
- People we spoke to told us they felt safe in the home. One person told us, "I feel safe in this place and with the staff." Another told us, "I definitely feel safe here".
- Staff understood their safeguarding responsibilities, the signs to be aware of and knew how to report concerns. One staff member told us, "Safeguarding is all about young people's safety, Vestige instils in us that our role is keeping the young people safe, and us safe". A regular agency member of staff working in the home told us, "[Safeguarding] is about being preventative not reactive. I have never had any cause of

concerns here."

Using medicines safely
● We found the date when medicines were opened had not always been recorded for all liquid medications which meant the provider could not be confident those medications were safe to use. It was noted our inspection took place at the beginning of a new cycle and all medicines were safe to use.
● We found tablet medication was only counted when it arrived in the home at the beginning of the cycle and not counted thereafter. The provider did not have an accurate record of the number of each tablet in the home and could not always ensure all tablets were accounted for.
● We reviewed the medicine administration records which confirmed people received their daily medicines as prescribed.
● Some people had prescribed 'as and when required' medicines which were administered in line with their individual protocols. We found the home had a general stock of 'as and when required' medicines that were not prescribed to a specific person, however these had not been administered. The chief operating officer arranged for the pharmacy to collect these medications.
● Medicines were administered by nursing staff who had their practice observed to ensure they were competent in this area.

Staffing and recruitment
● The provider was using a high number of agency staff in order to ensure a sufficient number of staff on duty. One person told us, "The ones that are permanent they are brilliant, absolutely brilliant. Sometimes they have too many agency staff and they don't respect you and don't want to get to know you." Another person told us, "The permanent staff have enough knowledge but not the agency staff; they don't have enough understanding. With so many people here struggling if a severe incident happens there isn't always people to talk to if you need to chat."
● The manager and chief operating officer informed us of the induction for agency staff and they were actively recruiting new staff in many different positions from residential youth workers to therapeutic staff. One agency staff we spoke with told us, "The first day I spent 6 hours having an induction. I spent time shadowing and I watched other staff."
● The provider recruited staff safely through the requirement of references and application to the Disclosure and Barring Service (DBS). A DBS check enables a potential employer to assess a staff member's criminal history to ensure they were suitable for employment.
● The provider had completed checks on the agency staff prior to them working in the home and used the same agency staff where possible to provide consistency of care to people.

Preventing and controlling infection;
● We were assured that the provider was preventing visitors from catching and spreading infections.
● 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 using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● 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.

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.

This is the first inspection for this newly registered service. This key question has been rated 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.

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

- The service lacked consistent direction and leadership as a result of management changes. There was an unclear strategy which meant systems and processes were not used effectively to review and maintain oversight of the service being provided.
- The providers systems were not operated effectively, monitoring processes failed to identify and ensure all current behaviours and risks were always included in people's risk assessments. For example, one person exhibited behaviours for three consecutive days before a risk assessment was completed. The behaviours and risks were not included in the completed risk assessment. A professional told us they found, "The risk plan was vague and not updated".
- The providers safeguarding systems were under-developed. The providers safeguarding children policy was out of date and failed to reference the current guidance which meant their procedures were not robust to ensure people's safety.
- We found children and adults were sharing the same space in the home, the providers systems did not ensure young people's safety from potentially inappropriate relationships or abuse from adults. The providers admission assessment systems and procedures failed to consider the risks of providing a service where adults and children were sharing the same space.
- We found the providers system of making changes to people's periods of observation was not clear. Systems in place had not included a clear rationale for the changes to observation periods made by the nurse. The provider also failed to establish a Multi-Disciplinary Team process for checking the nurse's decisions to amend observation and support levels.
- We saw people's daily records were not always recorded and the providers oversight systems failed to identify these gaps. These records were used to identify possible emerging risks and behaviours. Therefore, the provider could not ensure all relevant information relating to emerging risks for people had been identified and lessened. For example, one person's daily notes had not been recorded in for five days in the same week despite receiving the service.
- We found inconsistencies between people's daily records and incident reports, not all incidents were recorded in line with the providers policy and procedure. The providers systems failed to identify inconsistencies in people's records and failed to ensure oversight of the nature and number of incidents that had occurred; which restricted continuous learning and development in service delivery.
- The providers systems and process for the storage and management of medicines was not robust. We found the provider failed to continuously monitor medication stock to ensure all opened liquid medications were safe to use.

● The providers systems failed to ensure protocols for medication prescribed as 'as and when' required were accurate. We found protocols had not been signed by the manager or the prescriber to confirm the directions and conditions for administering these medications.
● The service retained a stock of PRN medication which was not prescribed to a specific person and the number of each medication was not recorded daily. The providers systems and processes had not identified the risks of having a stock of PRN medication and the potential risk of this stock being misused.

The lack of governance systems and oversight meant people were at risk of receiving poor quality care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they enjoy working in the home and said they felt supported by the manager. One staff member said, "I feel very part of the team we work as one unit." Another staff member told us, "The manager is responsive."
● The manager and chief operating officer acknowledged the shortfalls we found in the service and advised they were working towards compiling an action plan to address them.
● At the time of our inspection the manager was working their notice period and a new manager had been recruited. Since our inspection the manager had left the service and the new manager brought forward their date of commencement.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider did not always promote a positive culture that achieved good outcomes for people.
● Family members we spoke with told us the home did not involve them and communication with them was poor. One family member told us, "Management have not communicated that well with me at all." Another told us, "Communication has been very poor indeed." A third said, "They made so many promises but the communication between them and me is shocking. No feedback at all about [person's] care."
● Whilst people told us they felt engaged with their care and support they also told us the sessions to empower them and achieve good outcomes were not happening. One person told us, "If I could change anything it would be that the things that are meant to be happening, like sessions on my care plan, to make them actually happen."
● Family members told us the therapies people were receiving in the community stopped because they moved to the home to receive therapeutic input. However, we found people were not always receiving the therapy input required. One family member told us, "[Person] was supposed to go there for intense therapy but there's been a big delay in getting any therapy, [person] has had nothing since [person] started." The family member also told us, "[Provider] says [they] don't know where [person is] at on her pathway."
● Staff told us they received regular supervision where they could feedback and share their views of the service with the manager. One staff member told us, "My supervision is regular, every 6 weeks, I had some minor concerns which I raised and [the provider] listened and made changes."

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;
● While the manager and provider understood their responsibilities in relation to the duty of candour regulation, they failed to ensure they enacted it. Following an incident of self-harm, a family member told us, "I should have been contacted and wasn't."
● We found the provider had reported notifiable events however their systems and processes could not ensure events were reported to the appropriate authorities without delay.

Working in partnership with others;

● A professional told us the provided failed to always involve them in decisions about a person they had responsibility for, they said, "As the community service we would have expected to be invited to the Multi-Disciplinary Team meeting which has been hit and miss. The biggest issue we have had is communication."

● The provider told us they were aware their communication with other professionals had not been good, however they were working on this.

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
Treatment of disease, disorder or injury	The provider failed to ensure risk assessments were up to date and accurate. Incident reports were not always recorded and changes to observations were being made at handover however these were not always consistent with peoples presentations.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider failed to ensure oversight of the service provided

The enforcement action we took:

Warning Notice