Living Ambitions Limited

Whitwood Grange

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Whitwood Grange is a residential care home providing personal to people with learning disabilities. It accommodates up to 17 people in three separate areas; there are two six bedded houses and five self-contained flats. There were 11 people using the service at the time of our inspection.

People's experience of using this service and what we found
Whitwood Grange had experienced recent management changes. At the time of our inspection, an interim home manager was in post.

We found a lack of oversight over key aspects of the service such as the premises and infection control, assessment of people's capacity, formal staff support and outcomes for people living in the home. Some records we requested from the provider to demonstrate their quality oversight were not available.

Some areas of the premises were in need of repair. Infection control standards required improvement as staff were not consistently using PPE correctly and supplies of toiletries were not available.

People received their medication as prescribed, although storage arrangements and some recording was not adequate.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Assessments of people's capacity had not been appropriately completed. There was no evidence to show these decisions had involved people's representatives and they had not been reviewed.

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.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. Our findings demonstrated people did not always receive care which maximised their choice, control and independence. A lack of leadership meant there wasn't sufficient oversight of these aspects of people's lives. From our observations and care records, we found a mixed quality of staff interactions with people living in the home.

Day to day running of the home required a high usage of agency workers. Training records we looked at showed low completion rates, in particular for understanding the Mental Capacity Act, safeguarding people from abuse and the use of restraint.

With the exception of one relative, relatives and staff said people were protected from the risk of abuse. Relatives confirm they were involved in reviews of people's care, although they had initiated much of the contact with staff during the pandemic.

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 9 October 2019).

Why we inspected
We received concerns in relation to the use of restraint, the registered manager not highlighting workforce issues and declining management support, a lack of provider oversight and a lack of person-centred care. As a result, we undertook a focused inspection to review the key questions of safe 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 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.

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 improvements. Please see the safe and well led sections of this full report.

Following out inspection, the provider has commenced a programme of refurbishment at this home. Additional cleaning support to address infection control issues was provided for a two week period. A new home manager has been appointed who started in October 2020.

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 Whitwood Grange 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 breaches in relation to the management of risk, premises, infection control, safe recruitment practices and service oversight. You can see what action we have asked the provider to take at the end of this full report.

Follow up

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
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?

Inadequate

The service was not 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.

Whitwood Grange

Detailed findings

Background to this 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.

Inspection team
This inspection was carried out by two inspectors.

Service and service type
Whitwood Grange is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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, although they were not in day-to-day control of the home at the time of this inspection. An interim home manager was in post. We refer to them as the 'home manager' in this report. The registered manager and the registered 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 the inspection
We reviewed information we received about the service since the last inspection. We sought feedback from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. 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. We used all of this information to plan our inspection.

During the inspection
We spoke with the home manager and a support worker during our on-site inspection.

We reviewed records including three people's care records in detail. We also looked at three staff files in relation to recruitment and ongoing support as well as a variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We contacted six relatives and five staff by telephone to gather further feedback about the care people received at this care home.

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 inspection on 6 August 2019 this key question was rated as Good. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection
• Risks associated with infection prevention and control were found.
• Although the premises appeared clean when we inspected, there was no liquid soap in all sink areas and the home had run out of toilet paper for one person. There was no toilet paper in the staff toilet, instead there was kitchen roll. Staff were not responsive to running out of toilet paper.
• A work surface in a medication room was found to be sticky which was not appropriate for preparing medication.
• We observed two staff members not wearing a mask when supporting a person and at other times during the day a staff member was wearing the mask incorrectly. We also found two unattended buckets with cleaning fluids which put people at the risk of harm.
• Following our inspection, the management were unable to find any evidence of cleaning schedules which meant there were not records to show cleaning checks had been organised and undertaken in a structured way. No evidence of any enhanced cleaning in light of the COVID pandemic.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment) as people were at increased risk of infection as a result of these failings.

• Shortly after our inspection, the provider arranged for additional cleaning support over a two week period.

Assessing risk, safety monitoring and management
• The premises were not always in a good state of repair, suitable for people's living environment.
• Some aspects of the living environment had become damaged. For example, a hole in a lounge room ceiling had been present for several months. Some carpets looked worn and other areas looked tired. Relatives and staff told us these updates had been needed for several months.
• The provider told us these works had been delayed due to the Covid-19 pandemic. However, emergency works had not been risk assessed to determine the speed at which repairs were needed.

The condition of the premises was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Premises and equipment) as timely action had not been taken and risks to people had not been assessed.

• In October 2020, the provider sent us details of their refurbishment programme which included a commitment to redecoration, repairing the ceilings and replacing fixtures and fittings.

Using medicines safely

• People received their medication as prescribed, although storage arrangements were not safe.
• In one of the houses, controlled drugs were stored in a tin inside a lockable cupboard. This was not consistent with the Controlled Drugs Act to ensure these medicines (liable to misuse) were securely stored.
• One staff member told us syringes to administer medicine were being re-used which is not consistent with good practice. The home manager told us they had cleaned these the day before our inspection.
• The medicines room did not have clean surfaces to work on. One medication room did not have a sink area for staff to wash their hands. Daily medication room temperatures were not always recorded.
• Medication audits we were given were largely undated and not signed off. This meant it was not possible for us to establish how recent these checks were made.
• Daily records we looked at for one person showed they were administered medicines whilst they were in the bath which is not safe or dignified. This was being investigated by the provider.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate medicines were effectively managed. This placed people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment) as storage requirements for medicines were not effective.

• Medication administration records we looked at for three people showed they received their medicines as prescribed. Staff were trained in administering medicines safely and had their competency checked. Protocols were in place for the use of 'as and when required' medicines.

Staffing and recruitment
• Although people were supported by the number of support workers they were assessed as needing, we were not assured that people were always supported by staff who understood and were responsive to their care needs.
• Relatives and staff told us there had been a high turnover of staff. The home manager said, "We don't have a stable staff team. That is then breaking down people's routines and consistency." The provider was reliant on high levels of agency usage to cover staff shifts.
• Three recruitment files we looked at contained discrepancies. These concerned employment history which had not been followed up, a missing reference and one staff member's surname being recorded differently and not followed up.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safe recruitment practices were followed. This placed people at risk of harm. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Fit and proper persons employed) as records to demonstrate relevant background checks had been made were not available.

Systems and processes to safeguard people from the risk of abuse
• With the exception of one relative, family members and staff felt people were safe living at Whitwood Grange.
• Records we looked at showed 37 per cent of staff had not received training in protection and safeguarding training. The provider was taking steps to address this.
• We were not fully assured about safety because a concerning incident occurred in September 2020 which should not have been allowed to happen. We received assurances this was being investigated.

Learning lessons when things go wrong
• There was limited evidence of lessons being learned prior to our inspection.
• Following our inspection, the provider was taking steps to make improvements.

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 inspection on 6 August 2019 this key question was rated as Good. At this inspection this key question has 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• There was a lack of quality oversight and systems were not being used to monitor quality standards. Breaches of regulation we found at this inspection demonstrated that systems to assess and monitor the service were not sufficiently robust.
• From our observations of the living environment and what staff told us, it was evident there had been a lack of oversight over these aspects of the home, some of which still needed repair.
• The week before our inspection, the local authority infection control team visited the home to conduct an infection control audit and found numerous concerns. Some of these issues had been resolved by the time of our inspection and the manager was actively working on an action plan when we arrived. We asked the provider for evidence of their own infection control and mattress audits and were told these had not been carried out.
• Care plan audits we looked at showed people's records had been reviewed as this had been ticked, but there was no detail around what the care plan audit had found and the actions taken as a result.
• Assessments of people's capacity had not been appropriately completed. There was no evidence to show these decisions had involved people's representatives and they had not been reviewed. The provider did not have enough oversight to ensure capacity assessments had been appropriately completed.
• Accidents and incident records did not demonstrate staff always took appropriate action and follow up action was not always evident.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate good governance This placed people at risk of harm .This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because effective governance systems were not in place.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which 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
• A lack of stable leadership meant the provider was not operating with a culture which ensured good outcomes for people.
• We found evidence people were not always treated fairly and in line with equality legislation due to a lack of dignity, respect around medicines, home environment and cleanliness.
• At the time of our inspection, a home manager was temporarily in day-to-day control. This followed recent

changes in the leadership structure. Following our inspection, a new home manager had been appointed to commence working in October 2020.
• One person's behaviour was reported to have deteriorated as the provider had not explored different opportunities for them to stay in touch with their relative during the pandemic. The home manager told us, "Yes he misses (relative). I think it has been a contributing factor to (person's) behaviour." Following our inspection, the provider told us they had contacted other relatives during the pandemic.
• A staff member told us one person had been encouraged by staff to sleep during the day which meant they had a disturbed night time pattern and could not engage in meaningful activity at this time. Staff also reported that some care workers did not attempt to engage people in activities they (people) enjoy.
• There was a lack of evidence that all staff had been supported to gain the knowledge and skills required to care for people. Training in essential areas had not been completed or refreshed according to the training matrix. Following our inspection, the area manager told us staff were required to have completed required learning before the end of October 2020.
• Staff described having two supervision sessions each this year. The home manager said these were supposed to happen every six to eight weeks. There was evidence that one staff member had received an appraisal. The provider told us they would complete all appraisals by December 2020.
• There was a culture amongst some staff of inaction. For example, during the inspection there were several areas without toilet paper. We observed several people had no toilet paper in their bathrooms or in the communal areas. Staff had not raised this with the home manager who was unaware of the issue. Staff we spoke with told us this had happened previously. The provider did not have evidence of manager walk arounds for the two weeks prior to our inspection which would help identify issues such as this.
• Some staff were very caring and were fully committed to supporting the home manager to improve the running of the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others
• At the time of our inspection, there was limited evidence to demonstrate continuous learning and improvements to care people received.
• Following our inspection, the provider started to refurbish the premises and improve infection control standards.
• Following our inspection, the area manager told us the provider worked in partnership with professionals involved in the care of people at this home. They also said they had worked closely with the local authority since their visit in August 2020.
• Relatives told us they were consulted when the care needs of their family member were reviewed. However, relatives felt they had to initiate the majority of the contact with staff to obtain updates whilst they were not able to visit during the pandemic.
• At the time of our inspection, the provider had a positive behaviour support team providing support in reviewing people's care and support 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 12 HSCA RA Regulations 2014 Safe care and treatment (a)(b)(g) Sufficient infection prevention and control standards had not been maintained. The storage of medicines did not meet the regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment (1) Aspects of the premises had been allowed to stay in a state of disrepair.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed (2)(a) Records to demonstrate relevant background checks had been made were not available.

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 17 HSCA RA Regulations 2014 Good governance (2)(a)(b)(c) Management oversight was not evident over key aspects of the running of the service.

The enforcement action we took:

Warning notice served