

The Hesley Group Limited

The Paddocks

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

The Paddocks is a residential care home providing accommodation and personal care to 5 people at the time of the inspection. The service can support up to 8 people.

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

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and 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 supporting people with a learning disability and autistic people and providers must have regard to it.

Right support:

The Paddocks was located in a rural area of Doncaster and people were able to access community facilities and had links with local villages and shops. The location enabled and supported people to access nature and countryside walks. The registered manager ensured there was a culture of person-centred care and support. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Right care:

Care was person-centred and promoted people's dignity, privacy and human rights. Education and learning were promoted. Medicines were not always managed safely and information was not always correct in medication sheets. Risk assessments were in place and detailed, however, plans were not always followed by staff. For example, where people were at risk of ingesting hazardous substances, cleaning products were not always locked away. Some parts of the service were not clean enough and presented a risk to infection prevention and control. The provider was in breach of regulations in relation to safe care and treatment. Following the inspection, the registered manager took immediate action to address the areas that needed improvement.

Right culture:

The ethos, values, attitudes and behaviours of leaders and care staff ensured people using services were leading confident, inclusive and empowered lives. There was a positive culture of person-centred care for people living at The Paddocks. People were engaged and involved in developing and improving their homes and the service. Families told us they are involved in care planning and reviews and said they were satisfied with communication and engagement from the service. Families felt that the staff promoted a safe, consistent and predictable atmosphere which met people's individual needs and told us the registered manager was approachable and good at listening. Compliance and quality monitoring systems needed to be further strengthened and embedded into practice. The outcomes of audits and checks and needed to be regularly reviewed to identify compliance, lessons learned and areas for improvement. The provider was in

breach of regulations in relation to governance of the service. Following the inspection, the registered manager took immediate action to address the areas that needed improvement.

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

Rating at last inspection and update

The last rating for this service was requires improvement (published 2 June 2021) and there were breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

At this inspection we found the provider remained in breach of regulations.

Why we inspected

We carried out an unannounced comprehensive inspection of this service on 26 April 2021. A breach of legal requirements was found. The provider completed an action plan after the last inspection to show what they would do and by when to improve the governance of the service.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service remains requires improvement. This is based on the findings at this inspection.

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

Enforcement

We have identified breaches in relation to medicines management, safe storage of cleaning products and governance of the service.

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 from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 ●

The Paddocks

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 Health and Social Care Act 2008.

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

Inspection team

Two inspectors and an Expert by Experience carried out the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience telephoned people's families and had discussions about the quality of care.

Service and service type

The Paddocks is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Paddocks is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

Inspection activity started on 5 December 2022 and ended on 22 December 2022. We visited the service on 5 December 2022 and 14 December 2022.

What we did before the inspection

We reviewed information we received about the service since the last inspection. We asked for feedback and information about the service from the Local Authority and local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke to 5 family members of people who lived in the home about their experiences of care and support. We spoke to 4 members of staff including care team leaders. We walked around the home and looked in people's bedrooms, bathrooms, kitchens and communal areas. We took time to observe people in their homes and we reviewed medicines, care plans, staff recruitment files and incident management forms.

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained 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.

Using medicines safely

- Medicines were not always managed safely.
- There were missed signatures on the electronic medicine administration record (eMAR) and there was no action or follow up by the registered manager.
- Stock counts of medication did not match with the eMAR system count.
- Homely medication had been stored in the medicines cabinet but there was no record of this in the care plan. There was not a letter from the GP/pharmacist that confirmed the medication could be administered to the person safely.
- People's protocols for 'as and when required' (PRN) medication were not accessible on the eMAR system and could not be viewed by staff easily.

The provider failed to ensure proper and safe management of medicines. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, the registered manager took immediate action to address the areas that needed improvement.

Preventing and controlling infection

- We identified issues with a wet-room floor that was not sealed or in good repair. There were also stained and dirty bathmats.
- There were examples of wooden shelves and tables that were not sealed and some staff not wearing masks appropriately. This could increase the risk of cross-contamination and infection.
- We were not assured that the provider was promoting safety through the layout and hygiene practices of all of the premises.
- We were not assured that the provider was using PPE effectively and safely. We have also signposted the provider to resources to develop their approach

The provider failed to assess and prevent the risk of spreading infections, including those that are health care associated. This a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Following the inspection, the registered manager took immediate action to address the areas that needed improvement.

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was responding effectively to risks and signs of infection.
- 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.

Assessing risk, safety monitoring and management

- Risk assessments were in place and detailed. However, plans were not always followed by staff. For example, where people were at risk of ingesting hazardous substances, cleaning products were not always locked away.

The provider failed to assess the risks to the health and safety of service users of receiving the care or treatment. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Following the inspection, the registered manager took immediate action to address the areas that needed improvement.
- The service analysed incidents to identify learning that will help to reduce future incidents.
- Detailed analytical reports of incidents are shared with the staff who support people who live in the service.
- Families were involved in debrief meetings with speech and language therapy (SALT), psychiatry and psychology services that took place following incidents.

Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of harm and abuse.
- Staff had a good understanding of safeguarding policies and procedures.
- Staff knew how to recognise signs of abuse and who to report any concerns to so that action would be taken.
- A family member told us, "[Person] is a lot happier since they moved to The Paddocks. He is free from bullying."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Staffing and recruitment

- Staff were recruited safely. We looked at 3 staff recruitment files and saw evidence that staff had experience and qualifications relevant to the care and support they provided.
- Checks were carried out to ensure staff were suitable before they started working for the service. Disclosure and Barring Service (DBS) checks had been completed for all staff. They provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Visiting in care homes

- Visits from families were facilitated safely for people who lived at The Paddocks.
- Trips and overnight stays with families and for short breaks were planned with people and arranged safely.
- Family members confirmed an open approach to visits, one told us, "[I can visit] anytime I want to. On one occasion, I turned up unannounced."

Learning lessons when things go wrong

- An electronic system was used for recording accidents and incidents. Information was analysed and reviewed by the registered manager to identify lessons learned.
- Discussions with staff identified a 'reflective practice' approach to supervisions where lessons learned from accidents and incidents were discussed to support improvement in practice.

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained 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.

At our last inspection systems were either not in place or robust enough to demonstrate quality and safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

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

- Monthly medication audits were not effective and had not picked up errors in the stock counts of medicines.
- Risks were identified but not effectively reduced. For example, cleaning products were not locked away when a risk had been identified.

Provider oversight was not sufficiently robust. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, the registered manager took immediate action to address the areas that needed improvement.
- The registered manager received monthly quality reports that contained data and information about the performance of the service. This information was used to identify improvements to the service.

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

- People were involved in planned and regular activities including attending college, dog walks with family and going to music concerts.
- We heard from family members that "[Person] went to a theme park and went on a scary ride. He has been given opportunities to do things which he loves doing like rock concerts and theatres."
- Staff spoke knowledgeably about tailoring the level of support to each person's individual needs.
- The registered manager had developed a positive culture of person-centred care for people living at The Paddocks.

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

- There was an open and honest culture in the service. The registered manager understood their duties under duty of candour, to be honest when things go wrong.
- The registered manager had informed CQC about significant events and incidents which they are required to notify us about.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People who lived in the service were actively involved in reviewing the service and made suggestions about how the service could be improved.
- People were engaged and involved in the design and redecoration of their own homes. For example, 2 young men had made a decision to convert a spare bedroom in their home into a video games room.
- Family members told us the registered manager was approachable and good at listening.

Working in partnership with others

- The service worked closely with a range of professionals from support services including SALT, behavioural analysis and psychology.
- People were supported by staff to access the local community.
- A family member told us, "SALT is excellent. They moved [person] to an electronic Picture Exchange Communication System."

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 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider failed to:</p> <ul style="list-style-type: none">• ensure the proper and safe management of medicines.• assess and prevent the risk of spreading infections, including those that are health care associated.• assess the risks to the health and safety of service users of receiving the care or treatment <p>Regulation 12(2)(a)(h)(g)</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider failed to assess, monitor and mitigate risks to the health, safety and welfare of people using the service.</p> <p>Regulation 17(2)(b)</p>