Community Integrated Care

Sewells

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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.

About the service
Sewells is a residential care home providing personal care to five at the time of the inspection. The service can support up to seven people.

People's experience of using this service and what we found
Right Support
People were not supported to pursue their long-term aspirations and we found limited meaningful interaction with people.

Staff did not have the skills or training to recognise and support a person when they are feeling overwhelmed or distressed.

People were not always supported in a way that maintained their own health and wellbeing.

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

The service was focusing on improvements to the environment people lived in to ensure it was clean, well maintained and appropriate equipment was in place. Although not everyone was able to have access to the whole home. People were able to personalise their rooms.

People received their medicines when they needed them, and staff were mindful when people needed medicines.

Right Care
People were not always supported by a service that had effective systems in place to report and respond to accidents and incidents. Staff did not always understand how to protect people from poor care and abuse. Staff had training on how to recognise and report abuse, however staff actions did not always show they understood this.

People said staff were kind to them and we observed on the whole staff interacted with people in a kind way, however we found further improvements needing to be made to instil a culture of care in which staff

truly promoted people's individuality, protected their rights and enabled them to develop and flourish. There were long periods of time where people did not have any interactions with staff, and we found some staff using language and expressions that were not always respectful.

Staff were not appropriately trained to meet the needs of people to keep them safe which resulted in people being put at risk of harm.

People's care and support plans did not reflect their range of support needs. Staff either did not know where to find the information or gave inconsistent information in how to support the people.

Right Culture
People did not always have assessments in place, to identify risks people faced and how staff should manage these. Staff were not always knowledgeable about the content of these risk assessments. When risks to people were identified actions to mitigate these were not resolved in a timely manner which put people at risk of harm.

People were supported by staff who were not adequately trained to meet their support needs. People were not supported by staff who understood best practice in relation to supporting people with a learning disability.

The service had a recent change in management. Staff acknowledged this had helped improve the service and the support they received. Relatives and people spoke highly of the new manager in post.

People's quality of support was not always enhanced by the providers quality assurance system the provider had in place. Actions were not always documented, and it was unclear if actions were completed. This had an impact on people's care.

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 the service under the previous provider was requires improvement, published on 23 April 2021 and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

Why we inspected
We carried out an unannounced focused inspection of this service on 24 February 2021 under the previous provider. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

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, Effective and Well-led which contain those requirements. 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 has changed from requires improvement to inadequate. 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 Sewells on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to people safety, staff training and the lack of quality assurance systems in place at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below	**Inadequate**

Sewells

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
This inspection was completed by one inspector.

Service and service type
Sewells 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. Sewells 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 service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post, however there was a new manager that was going through the application process.

Notice of inspection
This inspection was unannounced.

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 the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with three people who used the service and two relatives about their experience of the care provided. As well as speaking with people we observed staff interactions and people's body language whilst in their home. We spoke with six staff which included the regional manager, the manager and support workers. We reviewed a range of records. This included two people's care records and medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

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. This was with a previous provider. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

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

- People's risk assessments were not clear or coordinated to ensure they were getting the support they needed. We found several examples where risks were not managed effectively. For example, risk assessments were not completed where people were at risk of developing pressure sores or their skin integrity. This had been identified at the last inspection and no further improvement had been made.
- People had risk assessments where they had a risk of choking, however we spoke with four staff who confirmed they were not adhering to the risk assessment. In addition, when speaking with staff they were unclear of the texture the food needed to be modified and did not know where the speech and language guidance was to check what the correct guidance was. This put the person at significant risk of harm.
- People that needed support with moving and handling did not have a clear, up to date manual handling risk assessment and not all staff had the training to support this. One staff member said, "To be honest [person] was on the sofa, I have not been here. I will watch what staff do and then I will have to work it out from there." We identified as part of the inspection this person had a number of bruises, one of which had not been recorded or investigated to find the cause. It was evident that staff had not had the correct training and this could have associated to the bruising.
- Staff could not always recognise signs when people experienced emotional distress. Risk assessments did not give clear guidance to staff and as a result staff were not supporting the person in a way that they needed. This resulted in the person getting angry and upset, which could have been avoided if staff supported in a consistent way. One staff member said, "Staff give me different ways to deal with [person], when they "kicks off" some say stick up for myself like saying don't do that [person], others say just leave them alone."
- Where safeguarding and risks emerged, involving alleged abuse between staff and people these were not investigated which meant potentially people continued to be put at risk of abuse.
- There was a lack of shared lessons learnt with the staff team and provider. The manager gathered the information relating to accident and incidents, however, did not effectively look at the overall trends and themes nor investigate in a timely manner.
- We found examples where people and staff were being put at risk as staff were not following the correct guidance which resulted in accidents and incidents. As there was no shared learning or reflection staff were unable to learn from this. This put themselves and people at risk of harm but also, receiving poor uncoordinated care.

Risks were not effectively managed, and systems were either not in place or not robust enough to demonstrate safety was effectively managed within the home. This placed people at risk of harm. This was a

continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite this, people and relatives said staff provided safe care. One person said, "I feel safe here." A relative said, "There are no concerns of day to day care, they are doing their best."

Staffing and recruitment
● Staff said they felt there was enough staff to keep people safe. However, we observed staff being task focused and did not have time to meet people immediate support needs, as well as emotional support needs.
● The provider operated a safe recruitment process; appropriate checks were undertaken to help ensure staff were suitable to work at the service. A disclosure and barring service (DBS) check and satisfactory references had been obtained for all staff before they worked with people. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely
● People were supported by staff who followed systems and processes to administer, record and store medicines safely, however staff feedback there were limited staff who were competency assessed and this impacted on the staff morale as there was pressure to cover. In addition, we found staff to be competency assessed by a designated staff member who had not received the training to be skilled to complete these competency assessments.

The provider failed to ensure staff were adequately trained. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Peoples care plans did not have up to date information about how to support people with their medicines. For example, one person's care plan stated they needed to have their medicines covertly. To administer medicines covertly means medicines are administered in a disguised format without the knowledge or consent of the person receiving them. The manager they said the medicines should not be administered in this way. Due to the incorrect information in the care plan we could not be confident that staff would not administer the medicines covertly.
● The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines and ensured that people's medicines were reviewed by prescribers in line with these principles.

Preventing and controlling infection
● Staff did not always use personal protective equipment (PPE) effectively and safely. We found a staff member consistently removing their mask from their face.
● The provider had infection prevention and control policy, which was up to date and detailed processes for staff to adhere to. For example, there were systems in place to keep the premises clean and hygienic.
● People were able to see their relatives or friends if they wanted to and there were no restrictions on this.
● The provider made sure that infection outbreaks could be effectively prevented or managed. Plans were in place to alert other agencies to concerns affecting people's health and wellbeing.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. This was with a previous provider. At this inspection the rating has changed to inadequate. This meant the effectiveness of people's care, treatment and support did not achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Care and support plans did not always reflect people's needs and aspirations. Support did not focus on people's quality of life outcomes. We found examples where care plans were not clear which meant staff would not be clear on how to support people. One person had a do not attempt cardiopulmonary resuscitation in place, however the care plan stated it still required a best interest meeting in order to ensure the correct decision-making process took place.
- Care plans failed to detail key health risks and how to manage these. One person was known for their skin breaking down, one person needed support with using a hoist and two people needed their food modified. None of which was detailed in the care plans.
- Staff failed to have the skills to support people in line with best practice and guidance. For example, one person had a positive behaviour support plan, although the manager knew how to support the person and started to model the support with staff, at the time of the inspection not all staff had the appropriate training. Staff were not adhering to the plan and staff were working inconsistently which impacted on the person. Staff confirmed they were all supporting the person differently which then resulted in the person becoming distressed.
- Care plans lacked information about people's long-term aspirations and people did not have much freedom, choice and control over their lives. One person had been in bed for nine months, due to changes in management and delays from outside professionals they had not got the equipment needed to support them to leave their bedroom. Since the manager had started this was something they were proactively supporting, however prior to this has meant the person could not achieve outcomes they wanted. The person described a number of things they were keen to do but at the time were unable to due to being in bed.
- People gave mixed views about the support they received from staff. One person said, "[Staff] helps me. Other staff won't help me when I need it."
- Some people said they wanted to be more involved in the development of the care plans and what is written about them daily. One person said, "I would like to be involved in my care plan."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Supporting people to eat and drink enough to maintain a balanced diet

- Staff did not ensure people were supported safely when eating and drinking. Where people were at the risk of choking, guidance had been produced by a health professional. However, staff were not adhering to this and people were being put a significant risk of choking. People were either not in the correct position

whilst eating or staff were unclear on the peoples support needs around their modified foods.
● Staff did not always ensure people had regular fluids. When reviewing the daily notes, it confirmed that a person did not have any fluids for five hours. This person had recently been admitted into hospital due to dehydration. Records continued to identify people would go for long periods of time without having any fluids.

The provider failed to ensure people had care that was person-centred, meeting their nutritional and hydration needs safely and met their individual goals and aspirations. This was a breach of regulation 9 (Person-centre care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since the change in management they have been proactive in ensuring people were having referrals for professional involvement when required. One example, being the manager was proactive in developing relationships with one person which meant after not feeling comfortable with intimate care they were happy for the manager to support them.

Staff support: induction, training, skills and experience
● People were not always supported by staff who had the relevant training. Not all staff had received manual handling, positive behaviour support and training where people were at risk of choking. We found a number of examples where untrained staff were supporting people who required staff to have these skills. This put people at risk of significant injury and in one case unexplained bruising was found.
● The provider did not ensure they met best practice when supporting people with learning disability and autism. We found only one staff member had training in learning disability and autism. The provider said this was something they were looking at developing.

The provider failed to ensure staff were adequately trained. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
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 MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
● The provider had failed to meet the legal framework to ensure decisions were made in people's best interest they were clearly documented. People had mental capacity assessments dated back from the previous provider in 2019. People's support needs had changed during this time as well as decisions about the care they needed. This was not reflected in up to date mental capacity assessments.
● Staff understood the principles of helping people make decisions through verbal or non-verbal means and how the mental capacity act was something they need to understand as part of their role. However not all

staff were positive about encouraging choice and control. One staff member said, "When we do meals, we will ask what they what, they always say chips. You have had chips. I ask them what they want to do. They want to be helpful. but sometimes they are just not helpful." Another staff member said, "We will ask them what they want for breakfast, if we have enough staff on do you want to go out to the shop, once a week we do the menu choice and there is always two choices of meals."

Adapting service, design, decoration to meet people's needs

- The provider and manager had plans in place to decorate and make adaptations to the property to ensure the environment was safe and well maintained. During the inspection works to the property had started to be completed. This included recently fitted bathrooms, kitchen, as well as new flooring within parts of the communal areas.
- People personalised their rooms and were included in decisions relating to the interior decoration and design of their home. One person said, "I like my bedroom I have everything in there that I like."

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 our last inspection we rated this key question requires improvement. This was with a previous provider. At this inspection the rating has changed to inadequate. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not 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

- This service was taken over by Community Integrated Care in June 2021, in which they understood the areas of improvement required from the previous provider. The provider had meetings with the local authority and the Care Quality Commission to outline their goals and actions to bring about the improvement. However, we have found in this inspection improvements have not been made and people continued to receive care that put them at risk of harm.
- The provider failed to ensure they consistently captured improvements needed in the service. There was a lack of audits and checks were not completed to assess the quality of the service and as a result failed to identify the risk associated to people eating and drinking, manual handling, support around people anxiety, staff competence and care planning. This meant they were unable to highlight were improvement were needed.
- The provider had failed to capture lessons learnt and did not share these with the staff team. This meant staff were not able to change their support practice for the better.
- The provider failed to capture themes from accident and incidents, nor did we find evidence that these were analysed in a robust way. This meant people continued to receive the same level of poor care. For example, there had been a number of incidents relating to a person becoming anxious which resulted in them causing harm to staff or themselves. Staff were not adhering to the support plan and this had not identified this on their action plan as an area of improvement.

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

- On the whole staff interacted with people in a kind way, however we found further improvements needing to be made to instil a culture of care in which staff truly promoted people's individuality, protected their rights and enabled them to develop and flourish. There were long periods of time where people did not have any interactions with staff, and we found some staff using language and expressions that were not always respectful. When speaking to one staff they said they were task driven and did not have time to engage in conversation. They said, "I think if we can get a consistent staff team, we can do it better. I am more of a task. More than the personal element. I like to do tasks to be organised."
- Staff fed back the morale in the team was low and this was partly due to the team dynamics. Some staff felt they were not a part of the team which meant communication between the team was affected. Staff

gave examples where this lack of communication and lack of a cohesive team inevitably impacted on people's care. One staff member said, "I do not feel part of the team. I am made to feel stupid. Staff do not give me the information I need."
● The provider and manager did not always consider the impact on people when reviewing the support, they provided. There was no consideration with how to meet people's long term-aspirations and how they would like to live their lives.
● The provider completed regular contact with the manager to share information, however the provider had failed to identify the failing in relation to the safety of people, staffing development and knowledge and the need to improve the overall culture of the service. The provider had reflected on this and said they had recently started looking at other CQC reports to share learning and look at way to improve the service.

The provider and registered manager failed to implement robust governance systems to ensure the quality and safety of the care provided met people's needs. The provider failed to ensure that action was taken to improve the care people received. This was a breach of Regulation 17(Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There had been a recent change in management. People and staff reflected on the changes which they felt had caused some staff to feel unsettled. However, they felt that recently this had changed and there was more stability and they felt happier with the support they received. One staff member said, "The manager has been really good. They run it really well. It is good. All the jobs that were left behind, continues from week to week. We are getting back to normality. I feel supported."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider had not sought feedback from people, those important to them and staff. However this was something that had been identified by the manager and during the inspection had sent surveys out to people and staff.
● Relatives felt they were able to talk to the management if they needed too, although communication could improve. One relative said, "They do phone up now and then and they fill me in when I get there. I am sure if things were not right, I would know."
● The manager had put on team meetings where they started to gain views of staff and to have discussions about the service.

Working in partnership with others
● The manager gave examples of how they had regular input from other professions to achieve good outcomes for people.