Caretech Community Services (No.2) Limited

Church Lane

Inspection report

21 Church Lane
Beasted
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Kent
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Tel: 01622730867

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Church Lane is a residential care home providing personal care adults with a learning disability and/or autistic spectrum disorder. The service can support a maximum of 20 people and there were 20 people living there at the time of the inspection. The service is split into two separate units. The first floor is called Inglewood Lodge and the ground floor is referred to as Church Lane. Both units had their own kitchens, dining rooms, lounges and shared bath/shower rooms. There were 10 people living in each unit. Some people had sensory impairments, epilepsy, limited mobility and difficulties communicating.

The service had not been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, independence and inclusion. The service was a large home, bigger than most domestic style properties. This is larger than current best practice guidance. There was a risk that the size of the service had a negative impact on people.

People's experience of using this service and what we found
The service did not always consistently apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence. There was an institutional approach to risk assessment and people living in the home had limited independence. For example, a kitchen area within the self contained flat in Inglewood lodge had been locked to prevent access because one person was at risk of injury if they entered the room alone.

Risk assessments had been updated and reviewed in a timely manner when incidents and accidents had occurred. However control measures to reduce the risks were not always effective. Further improvement was required to protect people from building related risks such as fire safety and window safety.

At the last inspection we reported about the risks of the unacceptable attitude and culture of some staff. The provider had taken action and staff had been suspended. However, there continued to be pockets of poor practice. Further improvement is required to improve the values, attitude and culture of staff within the service.

Medicines practice had improved, people had received their medicines safely. Medicines were stored securely. Staff had all the information they needed. Further improvement was required to improve recording.

People were not always protected from abuse. The provider had taken action when further allegations of abuse and abusive treatment had been reported since we last inspected. Incidents of potential abuse and abuse had been reported to the local authority safeguarding team. During the inspection we looked at an incident form which had been written the day before. This showed there had been an incident of violence

between two people living at Church Lane in the Inglewood Lodge unit of the service. This incident had not been reported to the manager, so they had not informed the local authority or taken appropriate action. After the inspection, we received new reports of allegations of abuse that had occurred since we inspected. This evidenced the systems and processes in place to keep people safe were not working effectively.

There was a mixture of permanent and agency staff supporting people at the service. There was no formal process to assess if staffing levels met people's needs. The operations director planned to implement a staffing dependency tool after the inspection to check that staffing levels met people's needs.

Quality monitoring processes were in place and were in the process of being embedded to ensure they were robust. Further improvements were needed. Where audits had taken place, action plans had not always been created to ensure actions to improve took place quickly. The provider had not submitted a statutory notification to CQC for an incident relating to one person ingesting nail varnish remover.

The provider had written to relatives following the last inspection under the duty of candour. The operational director and management team were also in the process of arranging meetings with relatives to discuss the issues within the service and the improvement plans in place.

People were starting to have more choice and control. Staff were in the process of being retrained in subjects including mental capacity and Deprivation of Liberty Standards as well as safeguarding.

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 service was rated Inadequate at the last inspection on 04 and 10 July 2019 (the report was published on 02 September 2019) and there were multiple breaches of regulation.

At this inspection enough improvement had not been made and the provider was still in breach of regulations.

This service has been in Special Measures since the last inspection. During this inspection the provider demonstrated that some improvements have been made. However, as only Safe and Well-led were inspected the service continues to be rated as inadequate overall. Therefore, the service is still in Special Measures.

Why we inspected
The inspection was prompted in part due to concerns in relation to the management of risks, response to accident and incidents affecting people's health needs. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only.

We found that the provider and management team had taken appropriate actions to respond to the risks and accident/incidents we had been informed about. However, the provider needed to make further improvements.

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 not changed from inadequate.

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 Church Lane on our website at www.cqc.org.uk.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains 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 well-led?

The service was not always well-led.

Details are in our well-Led findings below.

Requires Improvement

Church Lane

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.

Inspection team
The inspection was carried out by two inspectors

Service and service type
Church Lane 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. The registered manager was away from their role. The provider had put in place an interim manager. We have referred to the interim manager as the manager throughout our report. This means that the provider is 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
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 reviewed the information we held about the service including previous inspection reports. We also looked at notifications about important events that had taken place in the service, which the provider is

required to tell us by law.

We contacted health and social care professionals to obtain feedback about their experience of the service. These professionals included local authority commissioners and the local authority safeguarding team. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service and one relative about their experience of the care provided. Some people were unable to verbally tell us about their experiences, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with seven staff including; agency support workers, support workers, the deputy manager, the manager, the locality manager and the operations director.

We reviewed a range of records. This included four people's care records and multiple medicines records. We looked at a variety of records relating to the management of the service, including audits and checks and policies and procedures.

After the inspection
We continued to seek clarification from the manager to validate evidence found. We looked at training data.

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 last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

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

At our last inspection the provider and registered manager had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of Regulation 12 (Safe Care and Treatment) 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 12.

- Although risk assessments detailed safe ways of working with people, control measures to reduce the risks were not always effective.
- The approach to risk assessments was generic and had not always considered people's individual needs. One person living in Inglewood Lodge was at risk of injury from accessing a kitchen within a small self contained flat. The management team had locked the kitchen door to prevent anyone accessing the room. This meant the people who lived in that part of the service were unable to access their kitchen. The management team had not considered restricting the access to the flat so that it could only be accessed by the people who lived there.
- The management team had responded to an incident where one person had ingested nail varnish remover by removing everyone's nail varnish remover. This had been placed in the office for safe keeping. There were no records of individual risk assessments in place to look at the safe storage of nail varnish remover for each person that used it. However, the management team told us they had discussed the risks of nail varnish remover with the two people who used it and they had agreed they wanted to keep their nail varnish remover safe from the person and asked for it to be kept in the office.
- We identified risks for one person who was at risk of being supported in a way which did not meet their needs. We spoke with the management team about this and they agreed that the provider's positive behaviour support team (who were scheduled to work at the service in the coming weeks) would work with the person as a priority. This would enable staff to have clear guidelines to follow to ensure the person received consistent support.
- Since the last inspection, the provider had introduced a monitoring schedule in August 2019 named operation orderly. This put in place a series of checks that needed to take place within the service to ensure people, staff and visitors were safe. Operation orderly checks had started to be completed but these were not consistent across both units within the service.
- Fire alarm tests had been carried out in Church Lane but the fire alarm call points within Inglewood Lodge had not been checked in August 2019 at all. This meant the provider could not be assured that the fire alarm call points were working satisfactorily.

● A staff member had carried out a check on window restrictors in Inglewood Lodge and reported that there were three windows within the unit that did not meet the standards. They had filed the record of the check and this had not been reported to the management team. The operations director arranged for the provider's handyperson to carry out the repairs. These repairs were completed during the inspection to ensure people were safe.
● We observed a fire escape on Inglewood Lodge partially obstructed by a table and chairs. Two fire doors did not close adequately and one fire door which had a fire alarm sensor fitted was propped open by a dining chair. We reported this to the manager and operations director. They contacted the provider's handyperson who attended immediately to take action.

Individual risks relating to the health, safety and welfare of people had not been robustly assessed and managed. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People had guidelines around the use laxatives which reduced the risk of them becoming unwell from being constipated.
● The provider had implemented placemats which displayed people's food and fluid guidelines provided by healthcare professionals. This helped staff know and understand how to work with people safely which reduced the risk of people choking.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider and registered manager had failed to protect people from abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 13

● People were still not fully protected from abuse.
● At the last inspection we reported about the risks of the unacceptable attitude and culture of some staff. The provider had taken action and staff had been suspended. However, there continued to be pockets of poor practice. Three days after we inspected we were made aware of another incident where staff had acted inappropriately towards a person they were supporting. The provider had taken the appropriate action to deal with this. Further improvement is required to improve the values, attitude and culture of staff within the service.
● Seven days after the inspection we received information about incidents of abuse that had taken place since we inspected. This evidenced that systems and processes to protect people were not robust and had not been fully embedded to keep people safe from harm. The management team had taken appropriate action when these had been reported; such as informing the local authority safeguarding team and CQC as well as suspending staff.

● During the inspection we looked at an incident form which had been written by an agency staff member the day before. This showed there had been an incident of violence between two people living at Church Lane in the Inglewood Lodge unit of the service. This incident had not been reported to the manager, so they had not informed the local authority or taken appropriate action.
● We spoke with the manager and the locality manager about this and asked them to report this to the local authority and CQC.

● The provider had taken action when further allegations of abuse and abusive treatment had been reported since we last inspected. The provider had suspended some staff as a result of these allegations.

The provider had failed to protect people from abuse. This was a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Incidents of potential abuse and abuse which caused us to inspect the service had been reported to the local authority safeguarding team. There were clear records of this. Staff had sought medical advice when incidents had occurred. One person had ingested nail varnish remover, staff had taken immediate action and sought advice from the NHS 111 service and from the accident and emergency unit at the local hospital.
● People told us they felt safe. One person told us, "I feel safe, staff make me feel safe. I don't feel safe if people kick off but I tell staff and they talk with people and then they calm down." We observed people approaching and chatting with staff. There was accessible information about staying safe displayed around the service.

Staffing and recruitment

At our last inspection registered persons had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet service user's needs. This was a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 18.

● No new staff had started working at the service since the last inspection. Interviews had been held and new staff were in the process of being recruited. The provider was in the process of carrying out relevant recruitment checks.
● At the time of the inspection the service was using high numbers of agency staff to cover staffing shortfalls created by the suspension of 10 staff. There were five agency staff working on shift with two permanent staff in Inglewood Lodge and two agency staff working with five permanent staff within the Church Lane unit. Two waking night staff were deployed on each unit.
● The management team had carried out necessary checks to ensure that agency staff deployed had the necessary skills, experience and training to provide care and support to people.
● The service used regular agency staff who knew people well. One agency staff member told us they had been working five days a week at the service since the end of July 2019. We observed agency staff and permanent staff working together and providing consistent care and support. There were enough staff deployed to meet people's needs. People were supported to go to activities in the community with staff. One person went to a Zumba class and another person went shopping. Another person went out into the community on their own.
● The management team had put a rota in place to ensure there was a management presence within the service seven days a week. The management team told us they had all worked on shift to support people since the last inspection, this enabled them to observe practice and get to know people and staff well.
● Staff gave us mixed feedback about staffing levels; some felt it was sufficient to meet people's needs and others felt that more staff were needed. One staff member said, "It is not about how many staff are on but who is on; if there is a strong team on, we can manage." Another staff member told us, "Need more staff on so residents can go out and do more with them. If not enough on, you have laundry and paperwork, hard to balance spending one to one with people as well as this."

● The same staff member also said, "There is odd time when we have no choice so people are left on their own. There is enough to keep people safe in lounge. Gets harder if people need a bath but this is mostly in morning or evening when people are safe in bed."
● The management team had designed a form to log and record the one to one hours people received so they could demonstrate what additional care and support people were receiving.
● There was no formal process to assess if staffing levels met people's needs. We discussed this with the management team. The operations director told us the provider had a tool which they will implement in the service. This is an area for improvement.

Using medicines safely

At our last inspection the provider and registered manager had failed to ensure the 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.

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

● Although medicines administration records (MAR) did not always evidence that people had received their medicines as prescribed, stock checks showed that people had received the medicines they were prescribed. A stock count was carried out after each medicine was given which enabled the provider to carry out checks to ensure that people had their medicines as required. We counted the medicines and checked the stock records when we found gaps on people's MAR charts and found they had been given their medicines as prescribed. The staff member had failed to sign the MAR after they had administered the medicine. Further improvements were required to ensure that medicines records were complete and accurate.
● There was inconsistent practice in recording medicines in stock. People's medicines records evidenced the stock kept in their medicines cabinets. Medicines classed as controlled drugs were kept in a controlled drugs cabinet in a different place. The stock records for these medicines were recorded and stored in a differently, which could cause confusion. This was an area for improvement.
● Some people were in receipt of as and when required (PRN) medicines. PRN protocols detailed how they communicated pain, why they needed the medicine and what the maximum dosages were. This meant staff administering these medicines had all the information they needed to identify why the person took that particular medicine and how they communicate the need for it.
● People's medicines were stored safely in a locked cabinet in their room and the cabinet temperature was checked twice daily. This ensured they were stored according to the manufacturers recommended range to maintain the efficacy of medicines.
● A staff member told us, "At the last inspection the inspector picked up [person] PRN guidelines for Buccal was confusing, we now have guidelines in place from the epilepsy nurse."
● Medicines audits had been carried out by the management team. Actions to address issues found within audits had been completed swiftly.

Preventing and controlling infection
● The service continued to be clean, tidy and free from any unpleasant odours.
● Staff were provided with appropriate equipment to carry out their roles safely. There was a stock of personal protective equipment (PPE) available for staff to wear when supporting people with their personal care.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has now improved to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider and registered manager had failed to assess, monitor and improve the quality and safety of services, to mitigate risks, and to maintain accurate records. 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.

● Quality monitoring processes were in place and were in the process of being embedded to ensure they were robust. The provider needed more time to improve the service and plans were in place to do this.
● Where audits had taken place, action plans had not always been created to ensure actions to improve took place quickly. The kitchen spot check which was carried out on 22 August 2019 evidenced that the kitchen needed a deep clean of the extractor canopy and tiles. This had not been actioned. The window restrictor check which was completed on 26 August 2019 highlighted issues with three windows. An action plan had not been created and the management team had not been informed of the issues.
● It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating for their last inspection on their website. The report had been published on 2 September 2019 and was not yet displayed in the service. The operations director informed us this would be dealt with and put on display immediately.

Systems to monitor the quality and safety of the service were not yet embedded. Improvements had started but were in progress. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had a process in place to review and check each person's care plan, pen picture and behaviour support guideline. Some had already been completed. The provider's positive behaviour support team were supporting with this.

● Whilst the registered manager was not working at the service, the provider had put in place an experienced manager to take over as acting manager. They were supported by the locality manager and operations director.

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

At our last inspection the provider and registered manager had failed ensure that the Care Quality Commission had been notified without delay of significant incidents. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 18.

● The provider had not submitted a statutory notification to CQC for an incident relating to one person ingesting nail varnish remover.

The failure to ensure that the Care Quality Commission had been notified without delay of incidents is a continued breach of the Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

● The provider had notified CQC of other incidents that had taken place since the last inspection in a timely manner.
● The provider had written to relatives following the last inspection under the duty of candour. The operational director and management team were also in the process of arranging meetings with relatives to discuss the problems within the service and the improvement plans in place.
● The management team had placed posters and information around the service to ensure people and staff knew how to report any concerns to ensure people had opportunities to talk with the management team about any concerns or issues they had.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The culture of the service was improving, however time was needed to ensure that a new improved, respectful culture could be fully embedded into practice.
● People were starting to become more empowered and in control. Some people living in Inglewood Lodge had been offered and given door keys. One person told us they were now going out on their own into the community.
● The temporary manager explained how staff were being retrained and given additional support and guidance to help them work with people.
● The operations director explained that they had plans for the building. One person was moving out of the service in the near future. The management team had planned to change the layout and design of the Inglewood Lodge unit when the person leaves and reduce the number of bedrooms by one room. This will enable them to create a small flat, which the service will use as a stepping stone to prepare people who want to move on to independent living.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People had not yet received surveys in 2019 to formally ask them about their experiences of living at the service. People had been given opportunities to provide feedback through regular interaction with the

management team and through 'residents meetings' and 'listening sessions'. After the inspection the management team arranged meetings with relatives to explain their plans for the future and gain feedback.
● The senior management team had spent significant time within the service and had got to know people. People gave their feedback about the service to the management team. One person told us, "[Operations director] is [locality manager's] boss. [Operations director] comes and talks with people."
● A relative told us they were aware the service needed to improve but they were happy with the care and support their loved one received. They explained that staff knew their loved one well and this had enabled them to settle.
● We observed people living in the Inglewood Lodge unit felt comfortable around the management team. They were actively chatting with the temporary manager, the locality manager and the operations director.

Continuous learning and improving care
● The provider had put in place an improvement plan for the service. The operations director agreed to send this to CQC on a monthly basis to enable us to monitor the service closely.
● The management team were working with the commissioners from the local authority to drive improvement and embed new ways of working.
● One relative had nominated the Church Lane staff team for the Care awards 2019. They provided lots of positive information in the nomination which included, 'To conclude, happy residents, dedicated and happy team, appreciative brother who enjoys a good relationship with the residents, team and total peace of mind.'
● Staff meetings had taken place and staff felt things were improving. Staff said, "I feel there is improvement still needed but we are getting there. It is going in right direction, we are trying to run it as one; it is a learning curve"; "Communication is better. Change is a good, I feel that we are making changes for the better. We are here to provide good care" and "[Temporary manager] is brilliant. I get on really well with her. I come back to her to validate things and ask her questions. I would report issues to [temporary manager] and I have the confidence to do so."
● A staff member felt supported by the provider and the management team. They felt confident that the service was improving, and they would get things right. They said, "We are doing more dignity audits and peer reviews."

Working in partnership with others
● Records showed that incidents that had occurred since our last inspection had been discussed with the local authority safeguarding team for advice.
● The service had worked closely with a number of local authority care managers and the community learning disability team to review and assess people's care. There were different healthcare professionals involved with the service including, speech and language therapists, dietician, dentists, the doctor's surgery and pharmacies.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to ensure that the Care Quality Commission had been notified without delay of incidents. Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to manage risks relating to the health, safety and welfare of people. Regulation 12 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to protect people from abuse. Regulation 13 (1)(2)(3)(4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to embed systems to monitor the quality and safety of the service. Improvements had started but were in progress.

Regulation 17 (1)(2)