Individual Care Services

Individual Care Services - 11 Wembrook Close

Inspection report

11 Wembrook Close
Nuneaton
Warwickshire
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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

About the service
11 Wembook Close is a residential home, providing care and accommodation for up to four people. It provides care to people living with a learning disability and other support needs including autism. At the time of our inspection visit two people lived at the home.

People's experience of using this service and what we found
People did not receive safe care. Risks associated with people's care were not always identified, managed or mitigated. The provider had not effectively assessed staff had the skills, knowledge or experience they needed to provide care which ensured people living at the service were safe and others' safety was maintained. People's care plans did not always contain detailed or accurate information to help staff support people safely. The provider had not always ensured detailed records were kept of important healthcare visits or guidance.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support least restrictive practices. Where restrictive practices were used the provider had not always acted in line with the Mental Capacity Act 2005.

An 'infection prevention control' audit was carried out by CQC during the inspection. We found the provider was not consistently following government guidelines. Risks related to Covid-19 were not consistently well managed.

People were not cared for in premises that were consistently safe. Fire safety deficiencies had not always been acted on in a timely way. The provider had not ensured staff consistently had the equipment needed to keep people safe.

An admission to the home had not been well-managed by the provider and meant systems to manage potential abuse were not effective.

Governance systems, and management and provider oversight of the service were inadequate. Systems and processes designed to identify areas of improvement were ineffective. The providers policies and procedures did not always provide staff with the guidance they needed. Audits and checks had not identified the concerns we found.

The management of individual and environmental risks continued to require improvement.

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. (Report published 21 February 2018).

Why we inspected
We undertook this focused inspection because emerging risks had been identified by us and other professional bodies including the Local Authority and Fire Service. We had also received information of concern from staff and members of the public prior to our inspection visit in relation to the management of risks at the home and how people's needs were met. As a result, we undertook a focused inspection to review the key questions of Safe and Well Led only.

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 our 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 identified breaches in relation to the risks associated with people's care and management oversight of the service. The provider had not ensured effective systems and processes were in place to monitor the quality of the service and drive improvement.

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

Full information about CQC's regulatory response to the more serious concerns found during our inspection is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider to agree our ongoing monitoring of the service and discuss how they will make changes to ensure they improve. We will work with the Local Authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 six 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.

Individual Care Services - 11 Wembrook Close

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by three inspectors. Two inspectors visited the home. One inspector gathered information from the head of care via telephone conversations and email and spoke with staff and with a relative over the telephone.

Service and service type
Wembrook Close is a 'care home'. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
Our inspection was announced. We gave the provider 24 hours' notice of our visit because the service was inspected during the coronavirus pandemic and we wanted to be sure we were informed of the service's coronavirus risk assessment for visiting healthcare professionals before we entered the building.

What we did before the inspection

We reviewed the information we had received about the service since the last inspection and recurrent themes of any concerns. This included concerns shared with us from staff members and members of the public during 2021. Information of concern was shared with us from the Local Authority (LA) following a quality monitoring visit they had undertaken during March 2021. A Fire Service inspection undertaken during March 2021 had found numerous discrepancies where the provider was failing to meet the Fire Safety Regulations. This information helps support our inspections.
We used all this information to plan our inspection.

During the inspection
During our on-site visit to the service, we observed staff interactions with people and spoke with the head of service, care manager and a staff member on shift. We reviewed two people's care plans, risk management and medicine records in detail. We looked at a sample of records relating to the management of the service, policies and procedures and a sample of completed audits and checks.

During our off-site work we spoke with one person's relative and four staff. This included the head of care and regional manager.

After the inspection
We wrote formally to the provider to inform them of our serious concerns and requested additional documentation to be sent to us by 12 May 2021. We asked them to share evidence with us about immediate actions taken, which they did.

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 Good. At this inspection this key question had deteriorated to Inadequate. This meant the service was not safe. Risks were not well managed and there were risks that people could be harmed.

Assessing risk, safety monitoring and management
• Environmental risks to people were not managed safely. A referral to the Fire Service had been made by the Local Authority due to concerns they identified, including the fire risk assessment that had not been reviewed or updated since 2018 and contained out of date information. The Fire Service undertook a premises inspection during March 2021 and identified numerous fire safety deficiencies to the provider. Whilst we found some actions had been completed as required by the Fire Service to ensure the premises were safe, some actions were yet to be scheduled for completion.
• The head of service told us fire safety training had been prioritised for staff and all staff were trained. However, staff told us they had not received any fire safety training on how to support people in the event of an emergency. One staff member told us, "I've never been told how we would get [Name] out, we have no special equipment and I think we have to leave [Name] inside the house."
• Both people who lived in the home had personal evacuation plans in place (PEEPS) in case of an emergency. However, one person's PEEPS gave staff no information about safe evacuation and special equipment had not been considered.
• There was no clear procedure in place for staff to follow, especially if an emergency occurred at night, as there was routinely only one member of staff available in the home during the night-time shift.
• Some risks to people's health and wellbeing had been identified and actions put in place to minimise those risks. However, risk assessments were generic and did not always demonstrate a person-centred way of managing people's individual risks.
• Some known risks had not been assessed and did not have plans in place to guide staff in managing that risk. For example, one person had medical issues around continence care, but there was no information to support staff in minimising this risk. Another person had an identified risk of choking and whilst some staff had completed relevant training, they could not consistently tell us the safe first aid action to take for choking.
• Some risk management plans did not contain the detail staff needed to provide safe care. One person displayed behaviours that could cause themselves, and others harm. Prior to our inspection visit we had been informed of a particular response to this person that could exacerbate their anxiety. This information was not recorded in their care plan and staff had not been provided staff with the skills they needed to safely manage the risks associated with this person's behaviours.
• People were referred to healthcare professionals when a need was identified. However, records of the treatment, advice and guidance provided by healthcare professionals, including hospital attendance, was either not recorded or contained very limited detail. The head of service was unable to provide us with assurance that advice from healthcare professionals had been incorporated into people's risk management plans.

• The provider's processes and procedures for identifying and managing risks during people's transition into the service were ineffective and posed risks of harm to them and others.
• Staff told us they shared information between themselves, but a lack of records meant vital information to manage risks was not available to refer to, especially to new staff or agency care staff. For example, information related to health care needs.
• Equipment in place to reduce risks of damage to people's skin was not routinely checked by staff. For example, there was no procedure in place to check a person's pressure relieving mattresses to maintain their safety. We looked at this person's weight record and found their pressure relieving mattress was on a setting that was too high for their individual weight. This meant risks of the person's skin becoming sore or damaged were not effectively managed.
• Premises management required improvement to ensure people were always cared for safely. There were no window restrictors fitted at the home. Although bedrooms were on the ground floor of the home, the upstairs area of the home was accessible to mobile service users. One person had an identified risk of leaving the home unaccompanied, with reported incidents of this. This person had an inability to assess risks related to their personal safety. The provider's omission to ensure window restrictors were fitted posed risks of potential harm. We recommend the provider refers to the Heath and Safety Executive guidance.
• Radiators at the home were uncovered and posed a potential risk of burns to people if the they were hot. Whilst at the time of our visit staff were supervising the care of people at the home, this however did not mitigate the risk of people being harmed at night, for example, if they fell against uncovered radiators and were unable to move themselves.

Preventing and controlling infection
• The provider was not consistently following Covid-19 Government guidance. Feedback from a relative, and staff members, told us the provider had failed to fully implement government guidance, which the head of service told us was an 'oversight'. This meant the provider was not taking all the appropriate action to mitigate the risks and prevent the spread of Covid-19.
• One person's Covid-19 risk care plan instructed staff to take their temperature twice daily. However, there was no record of this ever happening and no equipment in place for staff to do this.
• We were not assured that the provider was preventing visitors from catching and spreading infections.
• We were not assured that the provider was admitting people safely to the service.
• We were not assured that the provider was meeting social distancing rules.
• We were somewhat assured the provider was promoting safety through the layout and hygiene practices of the premises.
• We were somewhat assured the provider was using personal protective equipment (PPE) effectively and safely. Staff understood the importance of using face masks, gloves and aprons to reduce risks of cross contamination, however, staff did not always know the safe way to put on, and take off, PPE.
• The home was clean and tidy and there were no unpleasant odours. However, staff were not consistently completing cleaning schedules to confirm the home was being cleaned in accordance with the provider's expectations.

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

Systems and processes to safeguard people from the risk of abuse
• The provider had failed to take sufficient measures to safeguard people from risks of harm and abuse. The head of service told us they had reflected that there had been failures on the part of the provider in safely planning one person's admission to the home. This had resulted in incidents of avoidable abuse of both service users.

This was a breach of regulation 13 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider had failed to ensure that we (CQC) and the LA were consistently informed about specific incidents as they are legally required to do so. The head of service apologised to us for their oversight and told us that going forward they would ensure information was shared with us.
• Staff were aware of their responsibilities to safeguard people and the action to take if they had any concerns about people's safety or poor practice by other staff members. Prior to our inspection staff had shared concerns with us about people's wellbeing and safety.

Using medicines safely
• Medicine administration records (MARs) had been completed accurately to show people had received their medicines as prescribed.
• Guidance was available to inform staff when they should give 'as required' medicine in line with national guidance for these medicines.
• There was no record of checks being completed to ensure medicines were stored at the appropriate temperatures because staff did not have the equipment needed to complete checks. Medicines were stored in a locked cabinet directly above a tumble-dryer, which posed risks of increased heat, the provider had no plans to change this storage arrangement.
• Prior to our inspection we had received information of concern about handwritten amendments to Medicine Administration Records (MARs) and these being unclear for staff to follow. A member of staff had told they feared errors would be made because of the unclear MARs. We had a telephone conversation with the head of service who assured us immediate improvement would be made. However, on our inspection we found amendments were not always countersigned by a second member of staff to confirm their accuracy. This continued to pose risks of potential errors occurring.

Staffing and recruitment
• Due to staff vacancies there had previously been a reliance on agency staff to cover gaps on the rota. The provider had recently undertaken a recruitment drive as they recognised continuity of care and a consistent staff team was an integral aspect of managing risks associated with people's emotional and mental wellbeing. Improvement in this area was work in progress.
• Staff told us there were now enough staff on each shift to enable them to provide safe care and manage risks and confirmed the use of agency staff had recently reduced. One staff member told us, "We used a lot of agency but that has really decreased, and it is has been nice not having the agency in. We are building a really nice team now."
• The provider undertook background checks of potential staff to assure themselves of the suitability of staff to work at the service, for example, collecting references and making checks into any potential criminal record.

Learning lessons when things go wrong
• Staff told us there were now opportunities for reflection following accidents and incidents to identify what had worked well and where improvements could be made.
• Staff felt some learning had taken place and improvement was now being made in managing risks related to behaviour that could challenge.
• The care manager spoke of an open environment where staff could feel confident to discuss issues to improve outcomes for people. They told us, "I go through the incidents with the staff to talk about whether there was anything we could differently, and I praise the team for what they do well. We reflect and talk through."

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 last inspection this key question was rated Requires Improvement. At this inspection this key question had deteriorated to Inadequate. Service management and leadership were 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; promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care
• The provider's governance systems to monitor the quality and safety of the service, required improvement.
• The provider had failed to identify one person's liberties were restricted throughout each day by staff and an application for a deprivation of liberty safeguard (DoLS) had not been applied for. This meant the provider was acting outside of the Mental Capacity Act 2005.
• There was no registered manager in place at the time of our inspection, the previous registered manager having been absent from the service since January 2021. The head of service, who had been in post since November 2020, had assumed oversight of the service in the absence of a registered manager.
• Audits had not identified gaps in important information including mental capacity assessments and risk management.
• Staff had completed some on-line training, however, their competencies had not been effectively assessed by the provider to ensure training had provided them with the skills and knowledge required.
• Audits in place to monitor the health, safety and welfare of people and the environment in which they were supported were not effective. For example, some staff told us they had never taken part in a fire drill. Fire safety logs had recorded faulty fire safety doors but remedial action to repair them had not always taken place in a timely way or some actions were not actioned.
• The provider's policies and procedures for moving and transitioning people into the service were ineffective and had led to poor outcomes for both people living at 11 Wembrook Close. One person had recently moved into the home. Whilst we acknowledged that the person had been unable to visit the home due to Covid-19 restrictions, no thought had been given to virtual tours/visits, picture books or virtual introductions to staff. No consideration or assessment had been made as to compatibility with the person already living in the home and the views of that person had not been sought.
• The provider had failed to assess staffing levels and staff skills and competencies prior to accepting a placement within the service. The head of service told us, "We should have invested in training for the staff before [person] moved here."
• The provider had failed to consistently ensure the level of staffing was provided for one person in line with their assessed needs. The head of service told us they, "were not aware of the reasoning for the staffing reduction." They added a service manager would have been present to support, however staff feedback to us did not reflect such support was consistently available.
• Government guidelines to protect vulnerable people during the Covid-19 pandemic had not been followed by the provider which placed people at potential risk. This meant the provider's guidance to staff did not

contain all of the correct information they should have followed.
• The head of service acknowledged that internal pressures caused by a poorly managed placement and the external pressures of Covid-19 meant they had concentrated their time on supporting the people and staff at the home. This had impacted on their role and responsibility for governance within the service. They told us, "My role specifically is to support with the governance, the management team and the care staff to ensure they deliver high quality care. Since I came into post, I haven't been able to achieve what I want to achieve because I am all things to all people at the moment."
• The provider had failed to maintain sufficient and accurate oversight of the service and to identify risk management was ineffective.

The above issues demonstrate a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider had recruited a new care manager who had started working the week prior to our inspection visit. They were going to have oversight of the service so the head of service could resume their original role and responsibility.
• Staff acknowledged the challenges of the previous four months. One staff member told us, "There is a lack of consistency in staff approaches to the people living here because the management have not made sure we all have the correct information or skills for the job." Another staff member told us, "The management have not been supportive, it really needs to be improved on. They are not approachable." A further staff member told us, "It is mere luck there has not been a major accident here because training has not been good, we've also had a constant change of managers."
• Some staff felt communication had improved recently. They told us this was having a positive impact on the wellbeing of both staff and the people living there and felt small steps toward improvement was being made by the head of service. One staff member told us, "[Head of service] has been more than helpful, he is open to discussions and he just listens. If you have got an idea, if you go and suggest something he will say we will talk about it and we will either try it or if there are too many risk factors he will explain why we can't try it."

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
• The provider did not have a robust system for the reporting of serious incidents. They had not consistently reported important events or incidents to relevant agencies, including us (CQC) and the LA. Following information of concern shared with us from staff and members of the public, we had requested statutory notifications be sent to related to specific incidents, which the head of service had done.
• During our inspection, a staff member told us about another incident which we had not been told about, as required. When we discussed this with the head of service, they explained they had not been aware of the incident. We have reminded the provider of their reporting responsibilities and the need for the effective reporting and recording of incidents by staff.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• One relative told us, "The managers have always been changing, I was not initially involved in sharing important information, it's only recently I've been involved by staff."
• There was no evidence of people's feedback being sought. For example, about new admissions to the home, so as to ensure compatibility.

Working in partnership with others
• Staff worked with other agencies to improve people's experience of care. These included health and social

care professionals. However, the provider had not ensured records were maintained about guidance given to ensure consistency of care.

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 The provider had not consistently assessed the risks to the health and safety of service users. The provider had not done all that was reasonably practicable to mitigate risks. The provider had not consistently ensured that persons (staff) providing care to service users had the competence, skills or experience to do so safely. The provider had not ensured the premises used were consistently safe. The provider had not consistently assessed the risk of, or followed the current government guidance related to the risk management of Covid-19.

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 Service users were not consistently protected from abuse because systems and processes related to admissions to the home were not operated effectively to prevent abuse of service users.

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 The provider did not effectively operate systems and processes to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. Risks related to the health, safety and welfare of service users and others were not consistently mitigated. The provider did not consistently ensure accurate and complete records were maintained related to the care and treatment provided to service users.

The enforcement action we took:

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