Living Ambitions Limited

Whitwood House

Inspection report

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West Yorkshire
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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

About the service
Whitwood House is a residential care home providing personal care and accommodation for up to 16 people. These people may live with a range of complex conditions, including profound and multiple learning disabilities, autism, sensory and communication impairments, acquired brain injuries and complex behavioural needs. There were 13 people living at Whitwood House at the time of our inspection.

People's experience of using this service and what we found
We found systems and processes used to ensure the service was running safely were not effective. We observed a lack of leadership, direction and oversight.

Risks associated with people's behaviours were not managed safely. Risks had not always been assessed and there was a lack of guidance about how to manage some people's behaviours. Incidents and accidents were not effectively reviewed to ensure lessons were learnt to drive improvements. We were not fully assured people were protected by the risk and spread of infection.

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.

Staff were not always deployed effectively to ensure people's needs were met. Staff did not receive effective competency checks on their performance and abilities to ensure they carried out their roles and responsibilities safely. Systems in place to safeguard people from abuse were not effectively implemented. Following the inspection, we referred four safeguarding concerns to the local authority,

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support:
People were subject to restrictive interventions that did not respect their rights. People had their own bedrooms but could not always access the shared lounges and kitchens.

Right care:
Care and support plans were not always reviewed or updated to reflect people's changing needs. Staff did

not always have the skill or guidance to respond appropriately in risky situations.

Right culture:
We identified a closed culture; people did not have their human rights upheld.

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

Rating at last inspection
The last rating for this service was good (published 19 April 2019).

Why we inspected
The inspection was prompted in part due to concerns received about the care people were receiving. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection. We have found evidence the provider needs to make improvements. Please see the safe, effective, and well-led domains of this report. Whilst we did not identify any impact on people, there was the potential for people to come to harm, as risks were not adequately assessed and there was an absence of key documentation.

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

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, premises, staffing and good governance at this inspection.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of 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**

Whitwood House

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
Whitwood House is registered as a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission although they were not in day-to-day control of the home at the time of this inspection. An interim home manager was in post. We refer to them as the 'manager' in this report. The registered manager and the registered provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we 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 prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
During the inspection we spoke with one person about their experience of the care provided. Other people were not able to verbally communicate with us, so we observed their interactions with staff members throughout the inspection. We spoke with seven members of staff, the manager, the area manager, the service manager and the operational excellence manager.

We reviewed a range of records both remotely and when we visited the office location on 13 May 2021. This included four people's care records and two people's medication records. We looked at 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.

After the inspection
We continued to seek clarification from the manager to validate evidence found.

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 good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risks were not managed or effectively monitored to ensure people's safety. For example, records showed one person frequently behaved in a way that placed staff and others at risk. Despite this, there was no behaviour risk assessment or positive behaviour support plan with guidance for staff about strategies to reduce risk and de-escalate situations. This put both the person and the staff at increased risk of harm.
- The provider was in the process of changing over its care records to another system. We found not all information had been transferred over, which placed people at risk of inadequate care and support. For example, one person had a speech and language assessment (SALT) which identified the person was at risk of choking but this had not been transferred over to the new support plans.
- We found risk assessments had not been reviewed on a regular basis and did not contain accurate and up-to-date information. For example, we found one person's epilepsy support plan had not been reviewed since 18 November 2018.

Learning lessons when things go wrong

- Systems to monitor accidents and incidents were not effective. We saw audits reviewed where incidents occurred but did not look in detail at time, place, person and situation to determine if there were any triggers that could be identified to reduce further occurrences. This meant managers were not able to evaluate learning from current performance to learn and improve the quality of the service.
- We found many incident records had not been effectively reviewed or acted upon. For example, records documented a recent incident where a person had caused damage to property after becoming agitated about not knowing which staff were on duty. There were no 'lessons learnt' documented on the incident form and no actions recorded to prevent similar incidents happening again.' Their support plan had not been reviewed or updated following the incident and consequently there was no information about how to avoid this happening again in the future.

We found no evidence people had been harmed however, the provider 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.

Preventing and controlling infection

- Risks associated with infection prevention and control were found.
- We found some areas of the home were not well maintained so could not be effectively cleaned. For example, cupboard units were damaged in the kitchens, there were areas of untreated wood near the sink unit and vinyl flooring was coming away from the floor and needed replacing.
- Staff were seen following the guidance regarding personal protective equipment (PPE) in relation to the

Covid-19 pandemic.

The provider had failed to ensure the premises was suitably maintained to enable effective cleaning, which is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staff we spoke with told us they regularly worked short staffed and one to one support for people was not always provided because of this. We observed people who were meant to be supported on a one to one basis with no support,

● Staff told us the service was short staffed and agency staff were used frequently. One staff member told us, "Weekends are when we are most short staffed." Staff said the use of agency staff had a negative impact on the quality of the service. A member of staff commented, "Some of the agency staff don't know the people in the service, which causes a lot of behaviours as they don't understand the triggers.''

● Staff recruitment and pre-employment records were in place; however, we found some small gaps. For example, one person had no references and another person had not provided their full employment history.

The provider had failed to ensure there were sufficient staff deployed to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Overall Medicines were managed safely, and people received their medicines as prescribed.

● All support staff were trained in the safe administration of medicines. Following training, checks of staff competency should have been reviewed at least yearly. We found not all staff had an annual review of their knowledge, skills and competencies relating to managing and administering medicines. We discussed this with the management team who said they would carry out a full audit of staff's competency checks and took appropriate action.

Systems and processes to safeguard people from the risk of abuse

● Staff we spoke with understood what it meant to safeguard people from abuse. In discussions, staff could describe how they would report concerns within the home

● However, issues we identified during the day did not support this. During the inspection we identified four safeguarding concerns and have made the appropriate referrals to the local authority.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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 Act 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- People's rights under the MCA were not protected as the Act had not been applied to ensure decisions were made in people's best interests.
- Where people lacked capacity, there was not always evidence of a best interest decision being made. When a best interest decision had been made this had not been documented in the person's support plan and there was not always evidence of people who know the person being involved in the assessments and decision-making process.
- People at Whitwood House were subject to restrictions upon their rights. For example, due to complex relationships between people living at the home, resulting in altercations between people and damage to property, some people had restricted access to communal areas and garden areas. One person told us they were afraid to use the lounge because of another person using the service. This meant people's rights under the MCA were not respected.

The failure to work within the principles of the MCA was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was not always working within the principles of the MCA

Staff support: induction, training, skills and experience
- Staff had either outstanding training or needed further training to enable them to support people using

the service. Staff told us they were not always confident they could meet people's needs safely. This was because some staff had outstanding training needs or required additional training to increase their knowledge and confidence in how to support people.

● Staff provided mixed feedback about the training provided. Some staff said the training was good quality; however, others commented it did not fully prepare them for the role. For example, one member of staff told us, "I have had training online to administer emergency medication but if I had to administer it, I would be too frightened. I think for this training it needs to be hands on and not just online." This demonstrated staff training was not effective.

●The provider did not always provide supervision and appraisal in line with their own policies and procedures. We found a number of staff had not had supervision or appraisal. One person said, "I couldn't tell you the last time I had supervision."

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.This was because the provider did not have effective systems in place to give staff appropriate support, training, supervision and appraisal as is necessary to enable them to carry out their duties.

We spoke to the provider about our concerns regarding staffing and asked them to take immediate action to address this.

The following day the provider had taken immediate and responsive action to address the concerns. A review of training was completed and training was organised to address outstanding training, or shadow other members of the team to increase their knowledge and build confidence in respect of other how to support others.

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

● The premises were not always in a good state of repair or suitable for people's living environment.

● We found urgent issues in relation to maintenance. For example, radiators were dented and corroding and needed replacing. There were no window restrictors in one of the first-floor bathrooms and doors and windows needed repair.

● Some aspects of the living environment had become damaged and in need of replacement. For example, there were insufficient items of furniture for the people living there and furniture was old and damaged. Decorations were tired and in need of refresh, carpets and vinyl flooring needed replacing.

The poor condition of the premises was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Premises and equipment) as the premises was in a state of disrepair.

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

● The management team had completed an assessment before each person started to use the service to ensure they were able to meet their care and support needs.

● People's protected characteristics under the Equality Act 2010, such as age, disability, religion, gender and ethnicity were identified as part of their need's assessment. Staff knew about people's individual characteristics.

Supporting people to eat and drink enough to maintain a balanced diet

● Staff supported people to stay healthy and referred people to other healthcare professionals as required. For example, we saw speech and language therapy (SALT) assessments in place for people who were at risk

of choking.
● Support plans had information about people's dietary needs, their preferences or cultural dietary requirements.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff routinely made referrals to other services and were familiar with health professionals and their scope of support. This included the dietician, speech and language therapy, GPs and district nurses.

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 as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- There had been a lack of leadership, direction and oversight. The lack of leadership had impacted on the care people received.
- During the inspection, we found multiple breaches of regulation. These failings demonstrated the systems to assess, monitor and improve the service were not sufficiently robust.
- Medicines audits had not always been completed regularly to identify errors, concerns and areas for improvement.
- There was no effective system for analysing, investigating and learning from incidents. This failure to conduct effective analyses of incidents meant opportunities may have been missed to identify ways of preventing future incidents, and exposed people to the risk of potential distress or harm.
- Records of care and support were not accurate or up to date and staff did not always have access to clear information about the people they were supporting. The failure to ensure complete and contemporaneous records meant we were unable to identify if people had received the care and support, they required.
- Staff had mixed feelings about the support they received from the management team. Some staff were positive and told us they felt they could go to the management team with their concerns. In contrast, other staff said there was a lack of communication and consistency from management. Some staff told us the service was not always well managed or organised.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, we wrote to the provider and asked them to take urgent action to address the most serious risks outlined in this report. In response, the provider developed a comprehensive and robust action plan detailing actions taken and planned to make improvements and reduce risk. Additional resources were immediately deployed to the service including enhanced management support and the support of a behaviour therapist.

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

- Care was not person centred and people were not always cared for in a safe way.

● Leaders in the home did not intervene or guide staff to ensure people received more appropriate care that met their personal needs.

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

● There was a lack of evidence to show how people and their representatives had been involved in care planning.

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

● Throughout the inspection the management team were honest and open with us. They acknowledged the shortfalls identified at this inspection and were eager to put processes in place to ensure people receiving care and support were safe and protected from harm.

Working in partnership with others: Continuous learning and improving care

● The manager and provider engaged and worked in partnership with others. They acted appropriately in response to the concerns we found on inspection.

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 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that care and treatment was only provided with the consent of the relevant person and act in accordance with the 2005 Act. Regulation 11 (1) (2) (3) (4)

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 ensure people's risks were identified and managed to ensure their safety. and infection control procedures did not ensure people were protected from the risk of infection. Regulation 12 (1) (a) (g) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure the premises were fit for purpose in line with statutory requirements. 15(1)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure sufficient

numbers of suitably qualified, competent, skilled and experienced staff were deployed effectively to meet people's needs.

Regulation 18 (1) (2) (a) (b)

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 systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity were not effectively implemented. (17(2)(a)

The enforcement action we took:

Warning notice