Pathway Healthcare Ltd

Cabot House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Cabot House is a residential care providing accommodation and personal care to 9 people. The service specialises in providing support to people with complex needs, learning disabilities, autism and challenging behaviour.

People's experience of using this service and what we found
Risks to people's health and wellbeing during the global pandemic of coronavirus were not consistently managed. People were exposed to the risk of contracting and spreading COVID-19 because the provider did not always follow government guidelines to keep people in care homes safe. This included guidelines on forming bubbles, isolation and visiting inside and outside the care home and infection control.

There were not adequate processes in place for assessing and monitoring the quality of the service. Systems had failed to identify that government guidelines and the providers own policies and procedures were not being adhered to. Processes were not in place to support safe visiting inside and away from the service. Staff were not always recruited safely.

Staffing levels were enough to meet people's individual needs. People were supported by a consistent staff team who knew people well. Staff were kind and compassionate and interacted with people in a positive and person-centred way. People and their relatives told us they were happy with the service they received.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support:
• The model of care and setting maximised people's choice, control and independence and measures had been taken by the provider to promote this. The service was part of a local community and there were local amenities and public transport options.

Right care:

• People received person-centred care and support which promoted dignity, privacy and people's human rights. People's needs and preferences were known and respected. People had access to meaningful occupation and opportunities to form friendships away from the service. People had access to assistive technology to promote their independence. The provider had taken measures to ensure the environment was homely and people's bedrooms were personalised with photographs and personal effects.

Right culture:
• The ethos, values, attitudes and behaviours of managers and care staff ensured people led confident, inclusive and empowered lives. People were empowered to have choice and control over their lives. People consistently received person centred support to live meaningful and active lives. People had opportunities to form community connections and make choices about the support they received.

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 13 June 2019)

CQC undertook a targeted inspection of Cabot House on 3 November 2020. The inspection was targeted to look at how the service was preventing and controlling infection. CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

At the inspection on the 3 November 2020 there was a breach of regulations. The provider completed an action plan after the inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

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.

We undertook this targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about infection control. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with how people were being supported to remain safe during the global COVID-19 pandemic, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Cabot 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 have identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to infection control, safe care and treatment and good governance.

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

Follow up

After the inspection we wrote to the provider about some of the urgent concerns found during inspection. The provider sent an action plan that informed us of the immediate actions they had taken to address our concerns.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led section below.

Cabot 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.

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

Inspection team
The inspection took place over two days. On the first day the inspection was undertaken by one inspector. On the second day the inspection was undertaken by two inspectors.

Service and service type
Cabot House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service is small, and we wanted to be sure there would be people at home to speak with us.

What we did before 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. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key

information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with one person who used the service and the relatives of five people about their experience of the care provided. We spoke with seven members of staff including the provider, registered manager, deputy manager, care workers, and administrator. 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 reviewed a range of records. This included two people's care records and multiple 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 provider to validate evidence found. We looked at data and quality assurance records. We liaised with the local authority about the service.

Requires Improvement

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 comprehensive inspection published 3 June 2019 this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection
CQC undertook a targeted inspection of Cabot House on 3 November 2020. The inspection was targeted to look at how the service was preventing and controlling infection and was undertaken as a direct response to an outbreak of COVID-19 in the service. At the inspection there was a breach of regulations. The provider had failed to ensure robust infection prevention and control practices to ensure people's safety and protect people and staff from the risk of infection. Staff did not always use personal protective equipment safely. This was a breach of 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection staff were provided staff with additional training on infection prevention and control and a separate area to change and store their clothing when coming on and off duty. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● We were not assured the provider was facilitating visits for people living in the home in accordance with the current guidance. The provider had failed to ensure visiting outside of the care home was in line with government guidance. People had been undertaking visits to indoor space's and overnight stays away from the care home during periods when government guidance restricted this activity from taking place. There had been a failure to consider or implement environmental changes or adaptions to support safe visiting to the service in line with government guidelines. We have signposted the provider to government guidelines on visiting away from care homes and care home visiting to help develop their approach.
● We were not assured the provider was preventing visitors from catching and spreading infections. Processes were not robust to support safe visiting to the service. Visitors were required to undertake a Lateral Flow Device (LFD) test on their arrival at the service and required a negative result before they could enter. However, there was a lack of information and planning to inform visitors on how to visit the service safely and ensure people remained safe during the visit. We have signposted the provider to government guidelines on care home visiting to help develop their approach.
● We were not assured the provider was meeting shielding and social distancing rules. All nine people living at Cabot House were living as one household. Government guidance required all members of the same household to be part of the same support bubble. This meant people who live together cannot form separate support bubbles or mix with other households. Seven people had formed support bubbles with other households and had been visiting these households on a regular basis since July 2020. We have signposted the provider to government guidelines on forming bubbles to help develop their approach
● We were somewhat assured that the provider was using PPE effectively and safely. At the last inspection

some staff were observed not to be wearing PPE correctly. At this inspection there was some improvement in this area and the majority off staff were observed to be wearing PPE correctly. We observed one staff with their face covering pulled down under their chin whilst sitting next to a person on the minibus. On two occasions we had to remind a member of staff to pull their face covering up to cover their nose as well as mouth. Failing to wear face masks correctly increases the risk of spreading COVID-19. We signposted the registered manger to government guidance on PPE requirements. Staff wore gloves and aprons appropriately and we observed these being changed regularly and in line with government guidelines.
● We were assured that the provider was accessing testing for people using the service and staff. Staff were undertaking polymerase chain reaction (PCR) tests on a weekly basis and LFD tests twice weekly. Eight people undertook a PCR test every 28 days which was in line with government guidelines. One person was not participating in regular testing.

There was a continued failure to ensure robust infection prevention and control practices to ensure people's safety and protect people and staff from the risk of infection. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was admitting people safely to the service. The service did not have any vacancies and people had not been admitted to hospital for an overnight stay. The provider had processes in place to support people being admitted to the service if circumstances changed.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. The service was clean and had a cleaning schedule in place. This included enhanced cleaning and sanitation of high touch areas.
● We were assured that the provider was making sure infection outbreaks could be effectively prevented or managed. Contingency planning enabled infection outbreaks to be managed effectively. Staff did not work across services and agency staff were not used. Staff received training in infection control, and we observed infection control processes in place such as solid laundry being placed in red bags.
● We were assured that the provider's infection prevention and control policy was up to date.

Assessing risk, safety monitoring and management
● Processes were not robust enough to ensure risks to people were identified and mitigated. We recognised the importance of home visits and personal family contact for people. However there had been a failure to ensure an effective process for identifying and mitigating risk to people, staff and the community when decisions were made to step away from government guidelines in place to keep people and others safe.
● Since July 2020 people had been having regular visits and overnight stays in their family homes. People visiting their family homes did not undertake a period of isolation on their return to the care home. Government guidelines in place from March 2020 until 17 May 2021 restricted people living in care homes from having overnight stays away or from visiting indoor spaces (public or private). Exemptions were made for medical appointments or overnight stays in hospital however people were required to isolate for 14 days on their return. The decision not to follow government guidelines on isolation or visits out of the care home had exposed people to a potential increased risk of COVID-19. We raised a safeguarding concern to the local authority about this.
● COVID-19 risk assessments were not effective in identifying some of the concerns found at inspection. Processes were in place to undertake social leave risk assessments before and after people participated in a social visit. We viewed six pre- social leave assessments and saw five had been completed after people had either commenced or returned from their social leave. For example, one person's pre and post social leave risk assessment for a three-night stay in the family home were both completed within two minutes of each other two days after the person had returned to the care home. For another person the risk assessment for a

six-night stay in the family home was completed two days after they had returned to the care home. This meant risks were not adequately identified and mitigated prior to the activity taking place.
● One person's pre-social leave risk assessment recoded they were going to visit two separate households. This did not correspond with their COVID-19 risk assessment which required them to remain in one household. Another person's risk assessment recorded it was in the person's best interests to travel into an area that was subject to a 'stay at home' order by the government. This meant travel in and out of this area was not permitted. The risk assessment did not consider the implications of this decision on the person, other people living in the care home, staff or the wider community. There was a disregard to government restrictions and guidelines to keep people in care homes safe. This exposed people to an increased risk of potential harm.
● There was a failure to fully explore and consider risks associated with visits to the care home. For example, feedback received to CQC and care home records evidenced a visitor had been able to spend 30 minutes in a room with their loved one. During this time, they participated in a planned activity which required face coverings to be removed. There was a failure to consider how this activity could have been made safer. There was also a failure to consider the vaccination status of one person undertaking the activity and others living in the care home. People who have not been vaccinated against COVID-19 are at a higher risk of contracting the virus. The failure to effectively plan and mitigate risks in advance of activities and visits to the care home placed people and others at potential risk of contracting and transmitting COVID-19.

We asked the provider to send to CQC an urgent action plan to show how they planned to implement government guidelines on care home visiting, updated 14 May 2021, to include arrangements for isolation and supporting safe visits to Cabot House. The provider responded to our urgent request for information and we received the assurances we were seeking.

There had been a failure to assess risks in relation to preventing, detecting and controlling the spread of infections. Government guidelines on care home visiting, isolation and household mixing had not been followed. This was a continued breach of 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other risks to people had been assessed. Risk assessments considered people's preferences and views and were reviewed on a regular basis. This ensured they remained current and risks were mitigated.

Staffing and recruitment
●Staff were not recruited safely. Processes in place to ensure the safe recruitment of staff were not being followed. We identified failings within the providers recruitment processes which meant people could not be assured that staff employed to support them were safe to do so. We have commented on this in more detail in the well-led section of this report.
● The provider was actively recruiting care staff. Staff new to the service told us they had received a comprehensive induction process which included training and shadowing more experienced staff. Staff told us they felt the providers induction and training programme equipped them with the skills and knowledge required to support people well.
● Staff felt they had enough time to adequately provide personalised support to people. Our observations were there were enough staff to meet people's needs. People and their relatives told us staff were readily available and on hand to provide people with support when they needed it and our own observations confirmed this. Personal care needs were met in a timely way and we observed staff spending time interacting with people and supporting activities of daily living and personal interests.
● People received support from a core team of staff who knew them well. Agency staff were not used. Permanent staff and a small team of bank staff covered additional hours when required. This ensured

people received continuity of care from a familiar team.

Systems and processes to safeguard people from the risk of abuse

● Systems and processes protected people from the risk of abuse. Staff understood how to report any concerns they had to relevant professionals and worked in line with the local authority safeguarding policy and procedures.

● People were supported to keep themselves and their belongings safe. Relatives told us they had confidence in the providers processes to protect their loved ones from abuse.

● Safeguarding training was completed by new staff during induction and there was a system to ensure staff undertook refresher training. Staff knowledge of safeguarding reflected up to date information and guidance.

Using medicines safely

● People received their medicines safely. Staff had received training in administration of medicines and only those staff who were assessed as competent were able to administer these. Our observations were people received their medicine safely and on time.

● Systems and processes were in place to ensure the safe storage, administration and disposal of medicines. There was a clear and safe process for administering 'as and when required medicines' (PRN). We observed safe practices for signing medicines out of the service to be administered when people were undertaking activities away from the service.

● People's medicine records (MAR) were audited regularly. This ensured that appropriate action was taken to safeguard people and implement measures to mitigate potential risks. MAR were completed accurately, and processes were in place to quickly identify any gaps in recording.

Learning lessons when things go wrong

● Systems and processes were in place to ensure that all accidents and incidents were recorded and reported appropriately. There was provider oversight and registered manager sign off, of all accidents and incidents records. This ensured outcomes were clearly recorded and acted upon and care plans and risk assessments reflected up to date information.

● Accidents and incidents were audited to identify trends and learning points and drive service improvement. The provider had a process to review and learn from incidents and prevent a reoccurrence. Outcomes were shared with staff so appropriate action could be taken to ensure people's safety and mitigate further risks.

● For example, a review of incidents showed there had been a marked escalation of behaviour related incidents in the week prior to an outbreak of COVID-19 being confirmed in the service. The registered manager told us this may have indicated that people had been feeling unwell prior to any signs and symptoms of the virus being apparent. Consideration will be given in future to spikes and increases of behaviour to identify people who may be asymptomatic or feeling unwell and will be used to seek medical diagnoses in a timely way.

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 good. At this inspection this key question has now deteriorated 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; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- There was a lack of effective oversight and monitoring of the service. Strategic governance and quality monitoring processes had failed to ensure compliance with government guidelines for working safely in care homes during the COVID-19 pandemic and the providers own policies and procedures.
- For example, there had been a failure to robustly consider or follow government guidance for care home residents at Christmas. Care home residents of working age were permitted to form a Christmas bubble with one other household. The rules on Christmas bubbles were law and included the following requirements. Visiting on 25 December only, not staying overnight, not forming a three-household Christmas bubble, not visiting a tier four area and testing and isolation on return to the care home.
- Between 21 December and 6 January five people stayed in their family homes for between one and 14 nights and one person visited for the day. The visits took place in family homes including when the area they were visiting was subjected to government tier four restrictions. These were London from 20 December 2020 and West Sussex from 26 December 2020. One person visited more than one household. Another person was part of a three household bubble. People did not isolate on their return to the care home. The failure to follow government guidelines on Christmas bubbles and tier restrictions placed people and others at increased risk of contracting and transmitting COVID-19 in the care home and community. We raised a safeguarding concern to the local authority about this.
- Management skills, knowledge and oversight did not foster a culture that protected people from avoidable harm. The registered manager was unable to demonstrate an up-to-date knowledge of government guidelines to keep people safe during the global pandemic. This included a failure to demonstrate and implement current requirements for care home isolation, visiting and forming bubbles.
- There was a failure to encourage or promote safe visiting to the care home. Relatives told us they had not been inside the care some for over a year and were required to wait outside when collecting their loved ones. This was observed during the inspection. Records showed there had been one visit inside the care home since government guidance changed in March 2021 to allow people to receive visitors inside the care home. We discussed this with the registered manager, and they told us visits to the care home were not encouraged. This was to reduce the risk of COVID-19 in the service and people visited family homes instead. This was contrary to government guidelines at the time which promoted indoor visiting and restricted care home residents from staying away overnight or visiting indoor spaces.
- Staff were not recruited safely. The providers quality checking processes had failed to identify significant

failings found at inspection in the way staff were recruited. These failings had not been identified or explored by the registered manager or provider. The registered manager told us they were not involved in the recruitment of staff and records viewed confirmed there was a lack of management oversight across the whole recruitment process. All aspects of recruitment were undertaken by an administrator, this included shortlisting and interviewing candidates. The registered manager was unable to demonstrate the administrator had received training in safe recruitment practices. The provider had failed to ensure staff were recruited safely and in line with their own policy.

● The provider's processes for monitoring records and quality assurance audits were not robustly applied. For example, the providers quality assurance checks had failed to identify a significant shortfall in the frequency of staff supervision against the providers supervision policy. The registered manager told us staff should be offered six supervision sessions a year and this was in line with the providers supervision policy. Records provided to us at inspection showed that some staff had not received formal supervision since 2019. As a result, staff were not receiving management feedback or opportunities for career development in a formal structured manner in line with the providers own policy.

After the inspection sought assurances from the provider about some of the urgent concerns found during inspection. The provider sent an action plan that informed us of the immediate actions they had taken to address our concerns.

The provider had not ensured there were adequate systems to monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Personalised care was central to the provider's philosophy. Staff demonstrated they understood this by telling us how they met people's care and support needs. Our observations showed a strong emphasis on meeting people's individual needs and ensuring people's preferences were known, recorded and met. Staff were fully aware of their responsibility to provide good quality, person- centred care.

● People were at the centre of everything the service did; the manager ensured people were involved with their care and staff understood the need to treat people as individuals and respect their wishes. One person told us the staff listened to them and we observed some positive interactions between staff and people.

●The staff team worked effectively together and were focused on meeting the needs of people. Care records and our observations of the care and support provided demonstrated this. The manager ensured staff had a clear understanding of their roles, responsibilities and contributions to ensuring a person- centred service

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others;

● The service worked in partnership with other agencies. These included healthcare services as well as local community resources. Records showed that staff had contacted a range of health care professionals. This enabled people's health needs to be assessed so they received the appropriate support to meet their continued needs.

● Feedback and ideas were regularly sought from the people who used the service. People had the opportunity to complete surveys and participate in keyworker meetings. The information from feedback was used to drive improvement within the service and the wider organisation. Relatives told us that their loved ones were respected and listened to and treated as equal partners in their care.

● Relatives were provided with the opportunity to provide feedback on the service being provided. Relatives told us they were pleased with the service their loved ones were receiving. We also received positive

feedback about the staff team who were described by relatives as "extremely caring" and "absolutely wonderful". One person told us they liked the staff very much.

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 12 HSCA RA Regulations 2014 Safe care and treatment There was a continued failure to ensure robust infection prevention and control practices to ensure peoples safety and protect against infection. There was a failure to assess risk in relation to preventing, detecting and controlling the spread of infection. Government guidance on care home visits, isolation and household mixing had not been followed.

The enforcement action we took:

Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured there were adequate systems to monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people.

The enforcement action we took:

Warning Notice