Headzpace Therapeutic Care Limited

Regus House

Inspection report

Office 123, Regus House, Herald Way
Castle Donington
Derby
DE74 2TZ

Tel: 07917916552

Date of inspection visit:
27 October 2021

Date of publication:
21 December 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Regus House is a supported living service providing personal care to people age 18 and over. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

CQC only inspects the service being received by people provided with 'personal care', this is help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided.

At the time of this inspection two adults who had a range of care needs including learning disabilities and autistic spectrum disorder were using the service. Of these, both were receiving personal care.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability 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.

Based on our review of key questions Safe, Caring and Well led, the 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 not always adequately supported to have choice and control of their lives and they were not always provided with enough details to support their decision making. Improvements were needed to ensure the care plans provided consistent and clear guidance to staff on how to support people. People's feedback was requested but not always listened to and acted on.
As a result of the above shortfalls people were at risk of their human rights not being upheld.

Right care:
Staff did not always understand how to safeguard people from abuse and avoidable harm and safeguarding incidents were not reported to CQC.

We found concerns about restraint practices and lack of guidance for staff on how to use restrain as a last resort. Furthermore, not all staff when the use of restraint is appropriate, this put people at risk of methods that could cause harm rather than de-escalate situations. We asked the provider to mitigate the safeguarding risks we found during this inspection immediately. The provider sent us evidence of how the risk was addressed.
The management of medicines was not always safe. Preemployment checks were carried out to make sure staff were safe to work at the service.

Right culture:
Not all staff received training to carry out their roles safely. We received mixed feedback from people and health professionals' regarding the staff's skills and ability to meet people's needs at all the times. Staff did not always display the skills and knowledge to meet people's needs. Records did not give a clear picture of incidents, triggers, or any analysis of learning to improve the service. People did not always feel they had choice and control within their homes. People did not always have choice in who provided their care.

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

Rating at last inspection (and update):
The last rating for this service was requires improvement (published 7 October 2021) and there were breaches in Regulation 11 (Need for Consent), Regulation 12 (Safe Care and Treatment) and Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and we issued requirement notices and warning notice. At the time of this inspection the provider was still within the time frame of becoming compliant with the regulations.The provider is due to be compliant with the Notice by 31 December 2021. We did not follow up the notice as part of this inspection.

The service rating has deteriorated to Inadequate.
Following this inspection, the service has been placed in Special Measures.

Why we inspected
We received concerns in relation to safeguarding service users from abuse and improper treatment. As a result, we undertook a focused inspection to review the key questions of safe, caring and well-led only.
We reviewed the information we held about the service. No new 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 requires improvement to inadequate. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvement. Please see the safe, caring and well led sections of this report.

You can see what action we have asked the provider to take at the end of this full report.

The provider has taken actions to mitigate the urgent risks and we asked for an action plan on how they will address the other concerns we identified.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Regus 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 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 have identified a new breach in relation to safeguarding service users from abuse and improper

treatment, and two continued breaches in relation to safe care and treatment and good governance at this inspection.

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

Follow up
We will request an action plan from 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 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 caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service well-led? The service was not well led. Details are in our well-led findings below.	**Inadequate**

Regus 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
Regus House is a supported living service for adults living with a learning disability.

The service provides care and support to people living in supported living settings, so they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

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 visit to the office, because it is a supported living service and we needed to make sure the registered manager would be available.

Inspection activity started on 27 October 2021 and ended on 8 November 2021. A visit to the office location took place on 27 October 2021.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make. We checked the information we held about the service and the provider, such as notifications. A notification is information about important events which the provider is required to send us. We also asked for feedback from the local authorities who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke to all (two) people using the service. We received feedback from professionals involved in people's care. We spoke to six staff working at the service, including the nominated individual, project director and four support workers. We looked at various records, including care records and risk assessments for both people using the service. We also looked at records relating to the management of the service. These included staff records, medicine records, complaints and compliments, staff rotas, audits and training records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two healthcare professionals who work in partnership with the service.

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 requires improvement. 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; Using medicines safely

At our last inspection 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 and we issued a Warning Notice. The provider is due to be compliant with the Notice by 31 December 2021. We did not follow up the Warning Notice as part of this inspection.

- Although the provider had taken some action to address risks, care plans were unclear, not up to date and uncoordinated. For example, we saw a person's care plan and risk assessment containing inconsistent and out of date information. As a result, the care staff we spoke to were not sure on some aspects of the person's care.
- Some staff practices at the service placed people at risk of harm. For example, there was an incident where staff lost sight of a person who required support from two members of staff at all times and the staff did not take appropriate actions. The incident was also not recorded and reported appropriately.
- One person reported they felt some risk management plans included unjustifiable restrictions, for example regarding their bedtime routine. This limited people's control over their lives and independence.
- Medicines care plans and administration records (MARs) did not reflect the best practice guidance on managing medicines for adults in community settings. For example, they did not contain information about people's needs and preferences. Poor record keeping placed people receiving medicines support and care workers at risk.
- Some medicines were not administered as per care plan. For example, one person's care plan stated the medicine should be administered at 9 am daily, however the record we saw had evidenced it was not administered consistently at the same time each day. This could impact on the efficiency of the medicine.
- There were no protocols for medicines that were taken 'as needed' to support the staff to administer them correctly. For example, one person's care plan listed four "additional medicines", however there were no protocols in place for why or when the medication was needed. This means people were put at risk of not receiving their medicine safely.

Systems and processes to safeguard people from the risk of abuse; Staffing and recruitment

- People were at significant risk of harm. Staff did not always manage safeguarding incidents appropriately. For example, there was no clear guidance for staff on what to do in the event of a person absconding despite this being a known risk. Some staff were not sure what to do when a person absconded.
- A person told us the staff do not respond consistently when they abscond. The lack of appropriate risk

mitigation in place put the person at risk of harm. We asked the provider to update the guidance immediately following our inspection. The provider submitted the evidence of updated guidance to us.
● Several safeguarding incidents that had occurred were not properly managed, recorded, investigated and reported. For example, when a person had absconded, the staff did not manage the incident in a safe way, and it had not been reported to CQC as required. This placed the person at risk of harm. The provider recognised that current safeguarding training was insufficient and planned for further safeguarding training to take place.
● We saw evidence of an incident where a deputy manager used unacceptable and obscene language when speaking to a person. The provider was presented with the evidence of this behaviour. The provider did not immediately suspend the member of staff. The member of staff was allowed to carry on working for the rest of the shift. This placed the person at risk of emotional abuse. The local authority requested, and the provider agreed for the member of staff to be suspended pending investigation of the incident.
● The provider told us that one person who used the service may need to be restrained as a last resort. However, not all staff who provided care and support received relevant and suitable training to make sure any control, restraint or restrictive practices were used in line with current national guidance and good practice, and as a last resort. We requested and the provider agreed to not allocate staff without the appropriate training to support the person.
● The provider told us one person who used the service was deprived of their liberty. A deprivation of liberty occurs where someone is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements. However, the provider did not provide us with a documentation to be able to verify this.

We found no evidence that people had been harmed however, systems were not robust enough to demonstrate that people were safeguarded from the risk of abuse affectively. This placed people at risk of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection. They confirmed guidance on management of absconding was updated and communicated to all staff.

● Recruitment processes were safe. Pre-employment checks were performed on staff to ensure they were suitable to work for the service.

Learning lessons when things go wrong
● The provider's quality assurance checks did not consistently identify poor practise. This prevented lessons being learnt when things went wrong.
● Lessons were not always learnt from incidents. For example, when there was a known trigger to a person's behaviour escalating, the provider did not take appropriate actions to mitigate the risks.

Preventing and controlling infection
● People were protected by the prevention and control of infection. Staff confirmed they maintained good hygiene and had access to personal protective equipment (PPE) such as aprons and gloves.
● The provider followed the regulations and guidance to help stop the spread of COVID-19.
● Staff told us they had received training in infection prevention and control and basic food hygiene.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.
This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
- People were not always treated with dignity, kindness or respect. We received mixed feedback about staff attitude and behaviour. One person told us, "They are bossing me around and tell me what time to go bed. Some [staff] are really good but some do not care. Some staff just sit and watch TV".
- We saw evidence of concerns about the way one staff member spoke to a person in ways that were not dignified or respectful.
- Staff did not always know people's preferences. For example, two members of staff told us a person liked to go to bed early but when we spoke to the person this was not the case. The person told us they felt under pressure to go to bed early.
- The staff we spoke to told us they had time to listen to people and communicate with them in a way to reduce agitation and conflict. However, we received mixed feedback from people about the way their behaviour was supported. One person told us, "Some just let me go and say do what you want, some stop me from leaving and some are nice and sit and talk to me".

Supporting people to express their views and be involved in making decisions about their care
- People were not always involved in making decisions about their care. The staff told us people were involved in making decisions about their care, however the healthcare professionals who work with the service were concerned that people were not always given sufficient information to be able to make their own choices and decisions.

Respecting and promoting people's privacy, dignity and independence
- The provider did not always ensure that staff schedules were organised so that people received care and support from familiar staff, in line with their personal preferences.
- A person told us and we saw evidence when people were in distress they were not always responded to in a consistent manner.
- The service did not always record or act on the particular needs of young adults when they were in transition to an adult service. For example, there was not enough guidance for staff on how to support young people with their relationships.
- Staff understood people's right to confidentiality and information were managed securely.

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 requires improvement. 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; Continuous learning and improving care
At our last inspection the provider's governance systems were not effective enough to consistently assess, monitor and improve the quality and safety of the service. This was as a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and we issued a Warning Notice. The provider is due to be compliant with the Notice by 31 December 2021. We did not follow up the notice as part of this inspection.

- Roles, responsibilities and accountability arrangements were not clear. For example, it was not clear who was leading on addressing shortfalls and breaches of regulations identified at the previous inspection.
- The provider did not understand or know how to meet their responsibilities for meeting regulatory requirements. Systems were not in place to ensure that incidents and accidents were identified and reported appropriately. CQC were not informed about safeguarding and other serious incidents. We are currently investigating this further.
- Leadership tasks including quality monitoring were not clearly delegated and as a result they were not effective. For example, medicines audit did not identify concerns about management of medicines and risk assessment audits did not identify they were insufficient and not always up to date.
- The systems and processes were not fit for purpose. The provider did not identify where quality and safety were being compromised and did not respond appropriately and without delay. For example, the provider did not follow their own Gross Misconduct Policy.
- The provider did not consistently implement relevant nationally recognised guidance, for example in regard to medicines management. As a result, people were put at risk of their medicines not being managed safely.
- Records relating to the care and treatment of people using the service were not always fit for purpose. For example, we saw some records did not reflect people's needs and did not provide sufficient guidance on how to respond to risk. As a result, people were put at risk of harm.
- The provider had plan in place on how to address the concerns found about the quality of the service, however high risks were not prioritised or addressed at the time of inspection.

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

● We received concerns from professionals who work with the service that the service was not well led. One person also told us that the service was not well led. The staff gave us inconsistent information about who managed the service on day to day basis.
● We found there was an increased workload for the NI due to the lack of governance and oversight of the registered manager.
● The provider told us they had an open-door policy and 24-hour support was available to staff. The staff we spoke with confirmed they felt the management of the service was fair, supportive and available.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The provider did not always respond to people's feedback. For example, one person specifically asked for certain staff not to be allocated for their care, however the feedback was not acted upon.
● We received concerns from numerous stakeholders working with the provider regarding proactive communication and following advice. There were concerned about the delays in obtaining requested information.
● The provider liaised with other professionals and provided evidenced of following some of the advice given, however this was not consistent at all the times. For example, when there were serious risks to people's safety the provider had not ensured staff were trained to respond appropriately.

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 understood their responsibility under the duty of candour. The duty of candour requires providers to be open and honest with people when things go wrong with their care, giving people support and truthful information. The provider apologised and provided support to a person when things went wrong with their 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
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not robust enough to demonstrate that people were safeguarded from the risk of abuse affectively.