Jeesal Residential Care Services Limited

Ashwood House - Norwich

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Ashwood House - Norwich is a residential care home providing personal care to up to seven adults with a learning disability or autistic people. There were seven people living there at the time of this inspection. The service accommodates five people in the main house with a shared communal lounge and kitchen. Accommodation for a further two people is provided in two self-contained flats.

People's experience of using this service and what we found
Based on our review of safe, responsive, and well-led the service was not able to demonstrate they were meeting some of the underpinning principles of Right support, right care right culture.
Right support
The model of care did not maximise people's choice, control and independence. The ability to provide person-centred care was compromised due to poor care planning, poor communication and poor consultation with relevant people, including relatives. The systems in place to promote person-centred support were not being utilised effectively. This included in relation to planning activities and maintaining important relationships.
Right Care
People were not receiving care that helped ensure risks to them and others were identified, assessed, and actions taken in response. Further work was required to ensure people were effectively supported with distressed behaviour and communication. Medicines were not always managed safely which placed people at an increased risk. People were not being supported by a robust incident reporting and management system. This included ensuring safeguarding concerns were identified and incidents drove learning and improvement. Serious concerns were identified with the governance systems in place. The systems in place had failed to ensure improvements in the quality of the service had been made. People's safety was compromised by ineffective and absent systems regarding the monitoring and mitigation of risk.
Right culture
People were not being supported by a service with effective governance that fostered a person-centred, open and inclusive culture.

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 11 September 2021). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At

this inspection we found the provider remained in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last three consecutive inspections.

Why we inspected
The inspection was prompted in part due to concerns received about staffing, medicines management and the management of the service. A decision was made for us to inspect and examine those risks. The information received raised concerns on how the service was applying the principles of Right support right care right culture. We assessed the application of these principles during this inspection.

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

Enforcement and Recommendations
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 and will take further action if needed.

We have identified breaches in relation to safe care and treatment, person-centred care, 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
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. This includes working 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.

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 responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Ashwood House - Norwich

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
Two Inspectors carried out the inspection.

Service and service type

Ashwood House-Norwich is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Ashwood House-Norwich is a care home without nursing 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. This means that only the registered provider, and not the manager, are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We undertook two visits to the service on 17 and 22 March 2022. This inspection was unannounced; however, we gave a very short period of notice for our return visit on the 22 March 2022. This was because the service is small and people are often out 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. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
Four of the people living in the service were able to communicate verbally with us. We spoke with these four people who used the service and eight relatives about their experience of the care provided. For those people unable to communicate verbally with us we observed the support provided. We spoke with 10 members of staff including the manager, deputy manager, four support workers and four agency staff members. We also spoke with the nominated individual when providing feedback at the end of the inspection. The nominated individual is responsible for supervising the management of the service on behalf of the registered provider.

We reviewed a range of records. This included recordings relating to four people's care and three people's medicines. We looked at one staff file in relation to recruitment. A variety of records relating to the management of the service, including audits and incidents were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested further information in relation to one person's medicine records and information relating to recruitment.

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 inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. 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.

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

- Care plans did not always effectively identify and address risk. There were limited risk assessments in place regarding identified risks and those that were in place were limited in information.
- Changes in relation to the support being provided to people had been made. However, the basis for the changes being safe was not clear, and no risks assessment in relation to these changes had been undertaken.
- Where risks had been identified we were not confident staff were following the plan in place to mitigate them. We observed staff practice that was not in line with one person's care plan and potentially increased their risk of harm.
- Further work was required to support people with distressed behaviours. Some people had frequent distressed behaviours but care plans to support people in this area were either poorly written or not in place. Incident reports and discussions with staff raised further concerns about how positive behaviour support was implemented. A positive behavioural support approach is recognised as good practice in the support of autistic people and people with a learning disability.
- Further concerns in relation to the management of people's continence and head injuries were also identified.

Risks to people have not always been identified and actions to mitigate risks had not always been taken. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines management was not always safe. Improvements were needed to the management of medicines. Changes on how often a medicine should be administered had been made for one person. However, their medicine administration record had not been updated to indicate this. This increased the risk of the medicine being administered incorrectly.
- For prescribed topical creams, body charts were not in place to indicate where these creams should be applied. Prescribed topical creams were also found unsecured in people's bedrooms. Such medicines can cause harm should they be ingested.
- For two people, front sheets containing information such as any allergies and other information relating to the safe administration of medicines were not in place alongside their medicine administration records. This information helps reduce the risk of medicines being administered unsafely.
- For medicines that were prescribed on an "as required basis" information on when this should be administered was not in place for some of these medicines.

Medicines were not always being managed safely. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● The systems in place were not robust in ensuring incidents involving safeguarding concerns were identified and acted upon. For example, we found one incident that had been recorded within daily notes which raised a safeguarding concern. No further action including an incident report or reporting to external safeguarding authorities had taken place. This meant we could not be confident all safeguarding incidents would be reported as required.

● A lack of clear care planning had led to confusion on an agreed plan of care which restricted at times one person's movement within the environment. This had also raised a concern that some staff were not always clear on how to uphold people's rights and promote equality.

● Whilst we could not be confident all safeguarding concerns were identified, we found when staff had identified safeguarding concerns appropriate actions had been taken. Staff had also undertaken training in this area.

Staffing and recruitment

● Since the last inspection there had been several changes to the staff team, including the management team. A number of long-term staff had left the service, including the previous management team, and this had resulted in an increased use of agency staff. Some relatives spoken with felt the increased use of agency staff and management changes had at times negatively impacted on communication with them.

● The manager acknowledged the use of agency staff was higher than they wished. The provider had a plan in place to reduce the use of agency staff in the service. Agency staff told us the information and support provided to them was good and enabled them to provide the support required.

● People were supported by enough staff during the day. We identified some occasions when night shifts were not staffed to the level the provider had deemed was required. The management team told us this had been due to an error with the management of annual leave which they had reflected and learnt from. We did not identify that these occasions impacted negatively on the support people received.

Preventing and controlling infection

● Our observations of the use of personal protective equipment (PPE) by staff raised some concerns about the effective use of ppe. We identified instances where some face masks were not being worn correctly to help minimise the risk of infection.

● There was no designated separate staff space for staff to take breaks within the service. This meant there was nowhere for which staff could easily take breaks and remove their masks in order to eat and drink without being within proximity of people living in the service. The manager confirmed this had been identified and work was under way to provide a separate outside internal garden building for this purpose.

● Staff and the management team told us staff were regularly undertaking COVID-19 tests in line with government guidance, however there was no oversight of these tests to help ensure this was the case.

● The environment was visibly clean and hygienic. Regular cleaning took place and records confirmed this.

Visiting in care homes

● There were no restrictions on visiting however some relatives told us they did not feel arrangements for visiting the service were always clearly communicated.

● Other regular communication such as telephone calls and video calls were in place although some relatives reported difficulties always being able to access these when they would like.

● People were supported to have regular contact with their family members outside of the service, this included visiting their relative's homes.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection of this key question in 2019 this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People's care plans did not always meet all their needs. Where needs had been identified appropriate care plans were not always in place. This included healthy eating and distressed behaviours. This meant there was an increased risk that the support delivered would not fully meet people's needs.
- We identified some instances where changes had been made to people's support with no clear written plan in place, relatives told us where changes had occurred, they did not always feel fully involved or consulted.
- We identified instances where staff had not proactively sought advice and input from other healthcare professionals in respect to people's changing support needs to enable proper and meaningful care planning.
- Whilst people were being supported to engage in activities, and in some instances, this was having a positive impact on their well-being, no care planning in respect to activities had taken place. This meant we could not be confident that activities in place were meeting people's individual needs and interests. Activity schedules that were in place were not being followed or up to date.
- Some relatives told us they did not feel able to comment on whether the activities taking place were appropriate and met the needs of their family members. This was because they had not been provided with this information and their family members were unable to verbally tell them how they spent their time.
- Systems that were in place to help review and ensure people's needs were met were not being utilised. This included monthly reviews of people's care and discussions about their goals and future plans.

Collaborative assessments of people's need's and preferences had not been carried out. The care provided had not been designed with a view to achieving people's preferences and needs were met. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

- Care plans in respect to people's individual communication needs provided limited information. Care plans referred to using signs or objects people recognised to aid their communication but the detail on what to use was missing. This was a particular concern with the level of agency staff used at the service.
- Staff spoken with and records we reviewed demonstrated that not all staff understood people's communication needs and how to meet these. This alongside the limited information on how to communicate with people meant we were not confident people's needs in this area were being met.

The care provided had not been designed with a view to achieving people's preferences and needs in respect to communication. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● No formal complaints had been received since our last inspection. Some informal concerns had been raised.

●The manager was open and honest about the informal concerns, however no written record of these had been made. This meant it was not clear how the concerns had been addressed or how they had driven any future changes in the support provided.

● People using the service and relatives told us they felt the manager was approachable and issues could be discussed with them.

End of life care and support

● No one was receiving end of life care and support at the time of the inspection.

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 failed to have effective governance systems in place to ensure compliance. This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider was still in breach of regulation 17.

- This was the third consecutive inspection where the provider had failed to ensure compliance with regulatory requirements. We identified serious concerns with provider level oversight which meant we could not be confident that improvements to the service would be made.
- Despite concerns being identified at the previous two inspections, at this inspection we found no provider level audits or service improvement plan was in place. This meant issues at the service had not been robustly identified and there was limited assurance that drivers for improvement were in place.
- The governance systems in place were not being used effectively to ensure issues were identified and improvements made. No recent quality audits had been carried out and the service had experienced a deterioration in the quality of support it was providing. This is reflected in the breaches of regulation and deterioration of rating as an outcome of this inspection.
- Where more specific audits had been carried out, such as in relation to medicines management, these had not been effective in identifying and making improvements and had not identified the concerns we found.
- Other systems, such as incident reporting, were not robust in capturing accurate data to support effective performance monitoring and evidence-based decision making.
- Systems to capture and monitor risks to people for example in relation to distressed behaviour were not being utilised. This meant we were not confident that systems were in place to monitor and mitigate risk.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and relatives were not fully consulted and engaged in the service because systems to support this were lacking or under-utilised. Several relatives raised concerns about the lack of communication and involvement. One relative told us, "I certainly don't feel as though I am part of the team" whilst another said,

"There is really no engagement with them at the moment."

● The lack of focus on proper effective care planning coupled with concerns raised by some relatives regarding poor consultation and communication raised concerns about how the service was fostering a positive, person-centred, open, and inclusive culture.

● Prior to the inspection, and during, we received comments anonymously raising concerns about the management of the service. However, all staff spoken with directly during the inspection were positive regarding the new management team and felt that staff changes including the management team were helping to instil a more positive culture within the service.

● People and staff told us the management team were more "hands on", working alongside staff. Staff and people told us the management team were approachable and listened to them. We found examples where the management team were identifying and addressing where improvements in staff practice was needed.

● The management team were relatively new in post and as such further work was required to provide assurance that positive cultural change had been embedded and sustained within the service.

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

● Relatives told us they were informed of incidents or concerns. However, due to concerns identified with the reporting of incidents in the service we could not be fully confident the requirements of duty of candour could be met.

● We identified one incident where duty of candour requirements had not been fully met.

Working in partnership with others

● Some concerns were identified in how proactive staff were in raising concerns and seeking input from professionals outside of the service.

● The provider was being supported by the local authority and other external parties. Despite this the quality of the service had deteriorated. This raised concerns about how effectively the provider was engaging in partnership working.