Camino Healthcare Limited

Vestige Healthcare (Dudley Port)

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Vestige Healthcare (Dudley Port) is a is a short stay service providing treatment for disease disorder and injury, diagnostic and screening procedures and accommodation and nursing care to nine people. People living at Vestige can be aged 16 to 65 and may have a diagnosis of learning disabilities or autistic spectrum disorder, mental health difficulties or misuse drugs and alcohol. The service can support up to 16 people, with a main house accommodating 14 people and two small houses on site accommodating one person each.

People's experience of using this service and what we found
People did not feel safe. People were being physically restrained without sufficient care pans and risk assessments. People were at risk of harming themselves and there was no risk mitigation to prevent this happening. The environment was unsafe. Medicines were not managed safely. There was a lack of awareness of safeguarding children. There were poor infection control practices in relation to COVID-19.

The provider failed to ensure there were sufficient systems and processes in place to enable them to have oversight of the service. Audits failed to identify significant concerns we picked up. People and staff did not feel listened to by the management team.

People were being physically restricted without the correct legal authorisation. 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.

People said they did not want to live at the home. People had no choice in what they ate. Peoples nutritional needs were not considered. People gave mixed reviews about whether staff knew them well. People did not feel there was enough for them to do and felt bored.

Staff and people did not feel able to express their views about the care provided. People did not receive dignified or respectful care. People did not receive person centred care.

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 guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. Care was not person-centred and did not promote people's dignity, privacy and human rights. The ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services lead confident, inclusive and empowered lives. This was impacting on people wellbeing.

During the inspection the provider told us they were hoping to seek alternative placements for some people and some people had undergone assessment for new placements. During and after the inspection other people were assessed for new placements.

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 inadequate (published12 November 2020) and there were multiple breaches of regulation. The service remains rated inadequate. This service has been rated inadequate for the last two consecutive inspections. The provider was asked to become complaint with the regulations after the last inspection. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted due to concerns received relating to the environment being unsafe, poor infection control practices relating to COVID-19 and the management of risk, in particular about behaviours that can challenge.
We served warning notices to the provider on 28 August 2020. We required the provider to make improvements to governance systems, safeguarding and safe care and treatment. We reviewed the warning notices and found the provider had not complied with them and continued to need to make improvements. Please see the all sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

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 breaches in relation to safe care, governance, safeguarding, consent, dignity and person-centred care at this inspection.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'inadequate' and the service remains 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 effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not caring.

Details are in our caring findings below.

Inadequate

Is the service responsive?

The service was not responsive.

Details are in our responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Vestige Healthcare (Dudley Port)

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
There were six inspectors involved in the inspection process with a maximum of three inspectors on site at any one time.

The inspection was carried out over four days. The team consisted of inspectors from adult social care, hospitals and the children's team.

Inspectors spent three days on site at the service and telephone calls to staff were made over four days by inspectors who were not on site.

Service and service type
Vestige Healthcare (Dudley Port) 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 did not have a manager registered with the Care Quality Commission. This means the provider is

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
We spoke with four people who used the service and two relatives about their experience of the care provided. We spoke with 22 members of staff including the nominated individual (who is also the provider). The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with the chief operating officer, the director of commercial operations, the manager, deputy manager, nursing staff, senior care workers, care workers, a consultant psychiatrist, an occupational therapist, an assistant psychologist, and the chef.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at four 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.

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 inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

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

At our last inspection the provider had failed to assess risks to people's health, safety and wellbeing. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We served a warning notice for this breach and required the provider to make improvements. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

• During this inspection we found significant concerns in regard to people's safety. One person told us, "I'm scared to be here, I don't want to be here, I don't feel safe." A staff member said, "I don't feel safe or compliant working here." We found concerns in regard to people safety at the last inspection. This meant lessons had not been learnt.
• Care plans and risk assessments did not clearly indicate at what point physical restraint should be used or what other techniques could be used prior to considering restraint. We found the same concern during the last inspection meaning the provider had not learnt lessons and made improvements. We observed an incident during the inspection where staff were unclear as to whether they should use restraint or not and had to seek guidance from the management team. This meant staff carrying out restraint did not have access to guidance on what restraints were safe for use and under what circumstances.
• There were people living at the home who had been identified as posing a significant risk of harm to themselves. Incident forms showed people had attempted to or succeeded in harming themselves. There was a lack of risk assessment and care plans in place for these known risks which placed people at immediate risk of harm.
• There had been no regular assessment of the environment to ensure it was safe for people despite the service providing care to people who presented significant risk of self-harm. One person told us they could find objects in the environment to harm with. There were four occasions, recorded in incident forms between September and November 2020, where people had found items to harm themselves with. In addition, one person told us they had found glass in the garden and handed it in to the staff. A staff member said, "It is not always a safe environment."
• One person had been identified as needing their food, fluid and weight monitoring due to increased risks associated with self-neglect and malnutrition. In October there were only three recorded food and fluid intake sheets for the person. There had been no weight recorded. The lack of monitoring placed the person at risk of harm.
• One person's staff support levels had been reduced, this decision had not been discussed or reviewed with the person or external professionals leading to them feeling unsafe. There were five occasions, across three

days, recorded in the person's daily notes where they disclosed they felt unhappy and not safe. There had then been a significant incident. They told us, "I did what I did yesterday [referring to the significant incident], I am not happy with myself … I have been telling them I need the staff levels back to what they were."

A failure to ensure care and treatment is provided in a safe way was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the second day of inspection, in response to the concerns raised, the provider told us they had started to review, and update people's care plans and risk assessments. We went back to check this and found some information had been put in place to keep people safe.

Using medicines safely

At our last inspection the provider had failed to ensure medicines were manged safely. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

• One person had two medicines in boxes and the instruction for administration on the boxes did not match the instruction on the medicines administration record (MAR). For one of the medicines staff told us they had followed the instruction on the box, for the other medicine staff told us they followed the instruction on the MAR. We raised this with the management team who later confirmed the instructions on the MAR were correct. This meant a person had been overdosed on one of their medicines.
• One person was prescribed emergency medicine to be given as and when they needed it. Staff told us they did not take this medicine off site when they went out with the person. There was no documentation to evidence staff were taking this medicine off site with them in case the person required it. This meant the person may not have access to potential lifesaving medicines when needed, placing them at risk of harm.
• We asked the management team to send copies of rotas to see if there were enough medicine trained staff on shift. The management team did not send these and could not tell us if they always had two medicines trained staff on shift. A staff member said, "Today I am the only qualified nurse on. Today I had to call the service director to sign [medicines] for me. … I have done some Saturdays and I am the only one [medicines trained]." Therefore, we could not establish if there were always enough trained staff to sign for medicines. This placed people at risk of not receiving their medicines safely.
• One person had been prescribed a medicine on an as and when required basis, but it was not clear who had prescribed it to them. We asked the management team to provide evidence of who had agreed to prescribe this medicine, but we did not receive this. Therefore, we were not able to ascertain if the person had been prescribed the medicine safely, placing them at risk of unsafe medicine administration.

The failure to ensure the safe management of medicines was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure acts to restrain people were proportionate and only carried out when necessary. 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.

We served a warning notice for this breach and required the provider to make improvements. Although we did not identify any inappropriate restraint, we did identify concerns with safeguarding practices. Therefore, the provider was still in breach of regulation 13

• The provider lacked awareness of their responsibilities to safeguard children and there was a lack of awareness or consideration to their legal status of children living in the home.
• There was no differentiation in terms of facilities, practice or care between children and adults. In addition, the provider and staff team were not fully aware of their responsibilities to safeguard children. This placed the children at risk of abuse.
• The children living in the home shared the same communal space as the adults. This meant they were not protected from potentially inappropriate relationships or abuse from adults. In addition, they were exposed to the adult's behaviours that challenged. This meant there had been no consideration to their emotional wellbeing of the children which placed them at risk.
• It was identified the children living in the home were particularly susceptible to both virtual and physical grooming due to their vulnerabilities. There was a lack of consideration given to the risks of child sexual exploitation and child criminal exploitation, there were no risk assessments for these areas. This meant the risks associated with exploitation were not fully assessed, understood or responded to placing children at risk of abuse.
• Known risks of exploitation were detailed in care plans but not risk assessed. In addition, there was no evidence of action, onward referral or liaison and information sharing with other agencies. There were no care plans or risks assessment in place to identify and mitigate this risk. This placed the child at risk of abuse.

The lack of safeguarding processes for children 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.

Preventing and controlling infection
• An infection prevention control audit was carried out by CQC during the first and second day of inspection. It was found the provider was not meeting government guidelines in regard to COVID-19. We have signposted the provider to resources to develop their approach.
• Staff and the management team were not consistently wearing masks in line with guidance. On the first day of inspection there were 30 occasions where staff were observed to be not wearing face masks correctly. These included not wearing masks, touching face masks when not removing or reapplying them and wearing facemasks with their nose or mouth exposed. We continued to observe this on the second and third day of site visits. This placed people at risk of contracting COVID-19.
• Three people had been in hospital and on return to the home had not been isolated. No consideration as to how to maintain social distancing had been given and no risk assessments were in place for the risks associated with COVID-19. A staff member said, "People are not isolated when coming back from hospital. There is nothing in place to manage that risk." This placed people at increased risk of contracting COVID-19.
• People were not being tested for COVID-19 in line with government guidance and no risk assessment was in place for this decision. This meant people could be asymptomatic and this would not have been identified. This placed people at risk of contracting COVID-19.
• There were no risk assessments in place for staff or people to identify risks in relation to COVID-19. There were people who lived at the home and staff who had increased risk of ill health if they contracted Covid 19 and this had not been assessed in line with government guidance. The lack of risk assessments placed both staff and service users at increased risk of harm should they have contracted COVID-19.

A failure to ensure care and treatment is provided in a safe way was a breach of regulation 12 (safe care and

treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• People and staff told us there were enough people on shift each day but the home was heavily reliant on agency staff. Staff told us they felt there was a large turnover of staff and this impacted on people. One staff member said, "Management are trying to bring in a new agency, but they don't seem to feel bringing in strangers is a problem, when it was." This meant people did not always receive consistent care from staff who knew them well.
• Staff recruitment was not always carried out safely. For example, we saw gaps in employment history that did not have an explanation. This meant recruitment processes were not always effective in ensuring staff were suitable for the roles prior to employment.

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 wasn't assessed. The previous rating of this key question was requires improvement. At this inspection this key question has 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.
• The requirements of the Mental Capacity Act 2005 had not been met. This meant decisions were being made for people without the necessary legal steps being taken. One person told us, "'I need more freedom, I need it back. I'm not allowed to go out on my own and I don't know why".
• DoLS applications had been made for four people two days before the inspection. These applications were not yet authorised. The applications contained various restrictions such as constant observation by one or two staff, 15-minute checks throughout the night and no access to the community without staff supervision. No capacity assessment or best interest decisions had been made in advance of these restrictions being placed on people. There was no clear rationale as to why the restrictions needed to be placed on people. This meant people were being restricted without consent or the necessary assessments.
• One person's care plan said staff could remove objects from them and stop them going out, if they posed a risk to themselves. There was no detail as to when these restrictions should be put in place. There was no explanation as to how the person would be stopped if they attempted to go out or how objects could be removed if they refused to hand them over. There was no detail as to how long the restriction should last. Furthermore, there was no information detailing if the person had capacity to make decisions and how these would be recognised.
• One person said they did not consent to the level of restriction currently placed on them. There were no mental capacity assessments or best interest decision to go alongside the documentation and there had been no recorded consultation with external professionals or next of kin. This meant the person was being restricted without consenting.

• One person was being restrained during incidents. There were no mental capacity assessments, best interest decisions or care plans to detail the reason why and when physical restrictions could be used. This meant the person was restricted of their liberty without lawful authorisation.

A failure to comply with the mental capacity act was a breach of regulation 11 (need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Supporting people to eat and drink enough to maintain a balanced diet
• There was no choice for people in regard to what they ate. Three people told us they were not given choices in food, only one meal option was provided. Staff told us there was one option and if people didn't want that there was no other hot food alternative, so people had to order and pay for takeout. One person said, "We don't get choice or options, it's the same food all the time".
• One-person, who was at risk of malnutrition, had a care plan that specified foods they liked to eat. We spoke to the cook and they were not aware of these and did not have them in stock. This meant care had not been taken to ensure people had food they liked to eat which would increase their risk of malnutrition.
• The cook was not aware of people's specific health needs. They told us, "No specialist foods or people who are diabetics." However, there was one person who was diabetic. There was no specialist diet recorded in the persons care plan, and the cook had not considered or explored health food options to promote healthy eating for people with diabetes.
• People who have a learning disability can have a free annual health check once a year. There was no evidence these checks had been discussed with people when they moved in to the home, therefore it had not been explored if anyone wanted to have this. In addition, people's oral healthcare had not been considered. This meant people's needs and preferences, around their health, had not been explored or discussed.
• There was some information in people care plans about their protected characteristics under the Equalities Act 2010 such as their disability, sexuality or religious needs, but this wasn't consistent for everyone. This meant staff may not have been aware of people's preferences.
• Peoples care plans lacked information about any pre-admission assessment that may have been completed. This meant it was unclear as to whether information gathered from the assessment was then used to create care plans and risk assessments to ensure people received a person-centred service.

A failure to make sure peoples care and treatment is appropriate and meets their needs was a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
• People gave mixed reviews about whether staff knew them well. People felt some staff did know them well, but others did not. There was a high volume of agency used and staff told us there were regularly new staff.
• A large percentage of staff training was out of date. The management team acknowledged this and said training compliance was part of their overall action plan. This meant training such as safeguarding children was not in date and we saw poor practices in regard to this area.
• The management team acknowledged that staff supervision had not been carried out in line with company polices and it was something they were working on as part of their overall action plan. A staff member said, "I had one supervision when I finished training three months ago, but nothing since then". This meant staff weren't always given the opportunity for learning and development.

Staff working with other agencies to provide consistent, effective, timely care; Adapting service, design,

decoration to meet people's needs
• The manager provider us with minutes of meetings that had taken place to discuss people's care. They said these had involved external professionals, but there was no list of who attended. We ask for confirmation of who attended but did not receive this information. One relative told us they had attended one of these meetings virtually and external professionals had also been there. However, they then went on to say there was never any feedback on actions that had been agreed following these meeting.
• The home did not have a homely feel. There was a number of areas of maintenance that needed to be completed including holes in walls, boarded windows, missing doors and missing glass panels. In addition, there were cigarette ends in the garden and broken lights lying on the floor outside.

Inadequate

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 wasn't assessed. The previous rating of this key question was good. At this inspection this key question has deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Supporting people to express their views and be involved in making decisions about their care
• People's gender preferences for staff had not always been upheld. One person told us, "I woke up and there was a man by my door. It made me feel unsafe." Another person told us they were allocated male staff to sit in their bedroom at night whilst they slept, and this made them feel uncomfortable. This did not demonstrate people's dignity, privacy was promoted.
• People told us they often weren't listened to. Comments included, "I'm worried for [person], no one listens to us", "They [management] aren't listening to people and people's views aren't respected here" and, "The bosses don't listen to the staff and the staff need to be involved [in decisions about our care]. The bosses are new and don't know us." A staff member said, "I feel really sorry for the people because they are not being listened to. When they raise their own concerns, they are fobbed off." This meant people weren't always able to express views about their care.
• Staff told us they did not feel listened to by the management team and they were not able to input or be involved in decisions made about peoples care and support. A staff member said, "If you raise concerns, I don't think they [management] listen. I tried to talk to them about the people because I know them better than the new managers, but they don't listen."

A failure to make sure people are respected and their dignity and privacy is maintained was a breach of regulation 10 (dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence
• Staff did not demonstrate an understanding of the importance of people's privacy, dignity and human rights. In addition, the management team had little understanding of the impact this had on people's wellbeing and needs.
• There were no clear plans in place for restricting people's privacy; for example, not being able to go in the bathroom alone. All of the people living at the home were being physically restricted or having periods of the day when they were constantly observed and there was no clear explanation as to why this was happening. This meant people's privacy and dignity was not always respected and expectations had not been clearly identified, recorded and then met as far as was practicable.
• A person told us when they were in their ensuite having a shower with the door open, a member of staff had entered their room to look in their cupboards. There were two staff present with the person at the time, but they had not stopped the staff member entering the room. This did not demonstrate the person rights to privacy were being upheld.

A failure to make sure people are respected and their dignity and privacy is maintained was a breach of regulation 10 (dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity
• People gave mixed feedback about staff. People felt some staff did listen to them and treated them with kindness and compassion, but other staff didn't. One person told us, "I tell staff what's wrong and they say, 'I don't want to know'". One person said, "Some staff genuinely care but some just don't care at all and are rude. I struggle to form relationships." This meant people were not always treated in a caring and compassionate way.
• Due to COVID-19 restriction, there had been limitations on when families and friends could visit the home. However, one person told us they had seen a person's relatives visit and they had been allowed to see and hug them, but when their relatives had visited the same day they were not allowed in the building. We discussed this with the management team who said national restriction had changed that day which changed visiting rules. It was not clear if this had been communicated to the person and the person told us they were very upset. This did not demonstrate a caring and compassionate approach.
• There was some information in people's care plans about their background and history, but this wasn't consistent for everyone. This meant staff did not always have access to information about people in order to provide a person-centred approach.

A failure to make sure people are respected and their dignity and privacy is maintained was a breach of regulation 10 (dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• Four people told us they did not want to live at Vestige Healthcare (Dudley Port). There was no evidence to suggest people had been given the opportunity to discuss their placement or overall happiness at the home. One person said, "I really don't want to be here. I want to cry myself to sleep." Another person said, "I don't like it here, I want to go home."
• The service was not tailored to meet the needs of people and ensure flexibility, choice and continuity of care. Care was not person-centred in accordance the right support, right care and right culture guidance. The ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services lead confident, inclusive and empowered lives. One person told us, "I'd like someone to speak up on my behalf to get me out of here."
• As detailed in safe, a person had expressed, on numerous occasions, they were unhappy about decisions made about their staffing levels. There was no documentation to evidence the person had been involved in reviews, assessment or decisions about this, even after expressing they were unhappy and felt unsafe. This meant the persons views were not considered when making decisions about their care.
• One person told us they did not feel their health and wellbeing had improved since living in the home. They said they had not been supported to access regular therapy or education. They said, "I have been given the opportunity to access online tutoring, but I haven't because I don't know what I'm interested in or what I want to do. I haven't had any help to talk about this". Another two people told us they either didn't receive therapy or it wasn't regular or structured. One person said, "There's no therapy or treatment, I hate it here."
• A relative told us they didn't feel their loved one had received appropriate therapy whist at the home, they said, "It's containment really with no progression." A staff member told us, "People are not getting therapeutic interventions."
• We discussed the lack of therapy with the occupational therapist and they said they do provide therapy sessions for people. There was some documentation in people's care plans to state what they wanted to achieve. However, there was no indication if they had been involved in creating and changing those goals, how they could be achieved and what steps had been taken to support them to achieve them.

A failure to make sure peoples care and treatment is appropriate and meets their needs was a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 did not always feel there was enough to do. Comments included, "It's boring [here] there's not a lot

going on. There's aren't enough activities" and, "I've been here three months and I'm bored out of my mind." A third person told us the activities were poor, and some activities offered were 'babyish'. A staff member said, "People are staying in bed until midday. No purposeful or meaningful activities. I feel that I am just a baby sitter."
• There was a lack of meaningful interaction and activity observed between staff and people. Staff were observed by all of the onsite inspection team across all three site visit days, to be sat outside people's room and not engaging in conversations or activities.
• People had been able to engage with their loved ones during the COVID-19 pandemic. This had been done in line with government guidance for example telephone calls or visits to the garden.

Meeting people's communication needs; Improving care quality in response to complaints or concerns
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• There was information in people's care plans about how they preferred to communicate.
• We asked the management team if we could view the complaint logs, they told us they had received two complaints in the last six weeks, and they were both resolved. These logs were not shared with us, so we were unable to see if complaints had been acted on and effectively handled.
• People told us they had raised concerns and made complaints, but no one had listened or acted on them. Comments from people included, "I feel the bosses won't listen to anything. They don't tell me what's happening" and "The manager and deputy are always too busy to talk, they know I want to leave."
• Out of the two relatives we spoke to, one felt they could raise concerns and they would be dealt with and one did not.

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 inadequate. At this inspection this key question has remained the same. 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.

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

• During the last inspection significant concerns were identified with the management of the home, safeguarding and safe care. The provider had not shared these concerns with the new management team, so they were not aware of the improvements we had asked the home to make. During this inspection there were again significant concerns identified in regard to the management of the home, safeguarding and safe care which placed people at risk of harm. This meant there was a lack of continuous learning and improvement.

• An audit had been undertaken by the manager on 12 October 2020, it identified care plans needed to reflect service user's needs. This action was due for completion by 31 October 2020. There were significant shortfalls in service users care planning and risk assessments meaning actions identified by the manager had not been addressed.

• A medicines audit was undertaken by the deputy manager on 15 October 2020. There were significant concerns identified in regard to medicines management. This audit identified some of the issues we found but they had not been addressed.

• People were not always receiving person centred, dignified and respectful care. The provider had no systems and processes in place to ensure people received their care in a person centred, dignified and respectful way.

• The providers systems and processed failed to monitor and oversee people's specific health needs. One person's fluid and weight was not monitored in line with their care plan. Therefore, not identifying potential concerns with lacking food and fluid intake. This meant appropriate medical attention or advice could not be sought if needed. Another person's care plan stated they required monitoring checks associated with their diabetes. There was no evidence to suggest these checks had taken place. Furthermore, there was no detail as to how frequently these checks needed to happen. This meant positive outcomes for people were not always achieved.

The lack of robust quality assurance meant people were at risk of receiving poor quality care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last inspection the provider had failed to implement quality assurance systems to identify areas for improvement. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We served a warning notice for this breach and required the provider to make improvements. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

• The provider failed to ensure systems and processes were in place and operating effectively. As a result, service users were exposed to the risk of ongoing harm. For example, there was no system or process to ensure all staff have received training in how to safely use restraint. The manager was not able to tell us if staff had appropriate restraint training. We have since received confirmation the staff involved in restraint have been trained.
• There were areas of the environment that were unsafe and posed a risk to people living at the home. Audits had failed to identify the environment was unsafe. Therefore, the control measures put in place were ineffective in keeping people safe. The provider had not identified these failings and had therefore taken no action to mitigate the risks to people's health, safety and welfare.
• The providers systems had not identified the government guidance around COVID-19 were not being followed. The providers systems and processes to monitor staff practice in relation to COVID-19 prevention were ineffective. The provider was not aware the home was not up to date with current government guidance on how to manage the impact of COVID-19. This meant staff and service users were exposed to the risks associated with contracting COVID-19.
• There was a lack of understanding in regard to the responsibilities to safeguard children who lived in the home. The provider had failed to identify children were exposed to risks and therefore had not acted to mitigate the risks. This meant children in the home were exposed to risks of harm.
• The providers systems and process had not identified the requirements of the Mental Capacity Act 2005 had not been acted in accordance with. Therefore, people were being restricted without the necessarily legal authorisations. In addition, the providers systems and processed failed to monitor and oversee safe recruitment processes. This meant safe recruitment checks weren't undertaken.

The lack of robust quality assurance meant people were at risk of receiving poor quality care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• There has not been a registered manager in post since 2017. The provider had a condition on their registration requiring there to be a registered manager in post. At this inspection there was a manager in post, but they were not yet registered.

A failure to have a registered manager in post is an offence of failing to comply with the conditions of registration (Section 33) of the Health and Social Care Act 2008.

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 and people did not always feel the management team were open and transparent with them. A relative told us, "Any incidents involving [person], I would find out through [person], they [management] wouldn't tell me."

Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The provider and manager had received regular input from external agencies and professionals to support

them with improvement and development of the home. There were times when the provider had failed to engage with this input as mentioned above, where CQC had identified and discussed areas of improvement. Although they had accepted some support there was a lack of evidence to suggest they had taken on board advice and guidance to make and sustain improvement.

• Staff did not always feel able to raise concerns with the management team and when they did they did not feel listened to. This meant potential poor practices could not be identified and addressed. A staff member said, "If we go to talk to management [about our concerns] they will not really hear us – they will say that is what you have been told to do, so you need to do that." As mentioned in safe a person had raised concerns about their staff levels, staff had also raised this concern and no changes had been made, resulting to a serious incident.

• Staff said they felt very worried to talk to CQC during the inspection as they feared they would lose their jobs. A staff member said, "The fear is that they may get rid of you if you speak up."

• Staff did not feel supported by the management team. One staff member said, "I do not feel supported at the moment."

• Staff competency was not assessed. A staff member said, "There's been no spot checks since new management have been in place." An agency worker said, "The management team did not check our competency." This meant staff could receive feedback about their practice and the opportunity to develop.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care A failure to make sure peoples care and treatment is appropriate and meets their needs was a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We served a notice of decision to vary the conditions on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect A failure to make sure people are respected and their dignity and privacy is maintained was a breach of regulation 10 (dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We served a notice of decision to vary the conditions on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent A failure to comply with the mental capacity act was a breach of regulation 11 (need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We served a notice of decision to vary the conditions on the providers registration

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment A failure to ensure care and treatment is provided in a safe way and medicines are managed safely was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We served a notice of decision to vary the conditions on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The lack of safeguarding processes for children 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 enforcement action we took:

We served a notice of decision to vary the conditions on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The lack of robust quality assurance meant people were at risk of receiving poor quality care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We served a notice of decision to vary the conditions on the providers registration