Adjuvo Care Essex Limited

Adjuvo Care Essex Limited - Halstead

Inspection report

Colchester Road
Halsted
Essex
CO9 2ET

Tel: 01787479729
Website: www.futures-carehomes.co.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Adjuvo Essex Care limited – Halstead is a residential care home providing personal and nursing care to 12 people with a learning disability and autism.

The service was a large home, bigger than most domestic style properties. It was registered for the support of up to 12 people. Six people were using the service. This is larger than current best practice guidance.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support because a lack of skilled, trained and supported staff meant people did not receive planned and co-ordinated person-centred support that was appropriate and inclusive for them. Therefore people were not supported to have maximum choice and control of their lives

People's experience of using this service and what we found

Staff told us there were insufficient staff in the service.

The service failed to provide adequate and meaningful activities for people.

The provider failed to learn lessons to ensure risks associated with individuals were identified, planned for and monitored effectively.

The service was not well led and management failed to have oversight of the service to drive improvement.

The service failed to encourage staff to maintain and develop their knowledge and skills. Systems for managing staff training was ineffective.

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

Rating at last inspection
The last rating for this service was requires improvement (published 5 March 2019) for the second time. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made.

Why we inspected

The inspection was prompted in part by notification of a specific incident. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

Following our last inspection we were informed by the provider of the decision taken to close the service, at that time a closure date had not been given. As part of our monitoring we carried out a focused inspection to review the Key Questions Safe and Well Led only.

We found shortfalls in the oversight, management, staff training and support and staffing levels which all impacted on the service's ability to support people safely and effectively. This put people's wellbeing at risk. Please see the safe and wellbeing sections of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Details are in our Safe findings below.

Is the service well-led?

Inadequate

The service was not well led

Details are in our Well led findings below.

Adjuvo Care Essex Limited - Halstead

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 team consisted of two inspectors and an assistant inspector.

Service and service type
Adjuvo Care Essex Limited - Halstead is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

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 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 seven members of staff including the registered manager, deputy manager and support workers. We reviewed a range of information. This included four people's care and medicine records. We looked at one staff file in relation to recruitment and staff supervision and a variety of records relating to the management of the service were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found and request any additional information. We looked at training data and quality assurance records.

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.

Staffing levels

● There were insufficient numbers of skilled and competent staff to keep people safe and meet their needs. A staff member said," We do try to take people out when we can, it is difficult because there are not enough staff. You cannot take a breath sometimes, let alone take a toilet break. Sometimes in the afternoon, there are times when we have to supervise other people as well as the person we are supporting on a one to one basis, we do this as a team effort. There is always a possibility of a problem if somebody becomes anxious or stressed and behaviours escalate." Another said, "Shifts are not being covered. We try to provide everyone with their one to one support hours but there are times staff will have to provide one to one support to two people at the same time. We try to take people out but some people won't go out with agency staff."

● Staff gave us numerous examples of the effect this had on people who used the service. . A staff member told us, ,"People are not going out which is causing them stress and associated behaviour that is challenging. With [person] this can lead to seizures." Another said," I think [person] should be encouraged to go out more but this requires more staff because they require two to one support out in the community, so it is not possible with the number of staff on duty. [Person] goes to bed because they are bored."

● Management had not based staffing levels on people's needs and the type and level of support each person required throughout the day in relation to going out and planned activities. Staff were not deployed in a way that was consistent with personalised care. For example, one person required 70 hours one-to-one support a week and 28 hours two-to-one support per week to access the community. To meet their needs, they required 'ongoing consistency from staff, and to be consistently supported by people who are familiar to their communication needs and wishes, they will respond better to staff they know.

We found no evidence that people had been harmed. However, action had not been taken to demonstrate staffing was being effectively managed. This placed people at risk of harm. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● One staff member had been recruited since the last inspection, however not all of the relevant information had been provided to allow for a full check of the staff members history. We raised this with the registered manager who agreed this had not been completed correctly.

Learning lessons when things go wrong

● Lessons were not learned to ensure risks associated with support and safety of individuals were identified, planned for and monitored effectively.

● People using the service had a learning disability and autism with associated complex needs. Despite

failings and safeguarding incidents occurring within the service, the provider and manager failed to provide relevant training and best practice for staff and promote a supportive and positive approach for people. Staff were not provided with training in subjects such as learning disability, autism, positive behaviour support, effective communication or Makaton. Subjects vital to equip staff to provide safe effective and appropriate support to people.

Assessing risk, safety monitoring and management

At our last inspection, people who use services and others were not protected against the risks associated with unsafe or unsuitable premises. This was a breach of regulation 15 (Premises and Equipment) 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 15

● The environment and systems in relation to legionella had not been upgraded by the provider following a risk assessment completed in April 2019. Risks were not always mitigated when they had been raised resulting in actions to be taken by the service. The registered manager confirmed that no actions had been taken however, these would be completed
● The provider's audit process did not include a system to ensure such checks were completed therefore safety issues had been left unnoticed.

We found no evidence that people had been harmed. However, action had not been taken to demonstrate the environment safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's care plans contained a wide range of assessments identifying potential risks, in relation to physical and verbal behaviours, health conditions, activities and community access. The assessments contained detailed guidance for staff on how to mitigate these risks, in the least restricted way. However, staff continued to not follow people's care plans and risk assessments. For example, one person was at risk of choking and required supervision when eating. However, staff had given the person food and allowed them to eat alone in their bedroom, despite the known risks. This meant that the person was put at risk of harm by staff. We spoke to the registered manager about this incident, who told us action was taken against the member of staff.
● Fire safety arrangements continued to place people at potential risk. At the time of inspection, a fire door had been damaged in the communal hall way and had not been identified as a risk. Due to our concerns about people's safety, we referred our concerns to the local Fire Authority who were due to return to the service to ensure they were compliant with fire safety regulations.
● Risk assessments relating to the environment were now in place. This included Personal Emergency Evacuation Plans (PEEP) for use in case of an emergency

Using medicines safely
● People did not always receive their medicines as prescribed. Relevant national guidelines about storing, administering and disposing of medicines were not always followed. One person had been prescribed medicines that required cold storage. However, staff had not followed the specific guidance on storage and had left it at room temperature. As a result, the medication was not given for two days until a new prescription had been received.

● Medication Administration Records (MAR) were not always completed in line with national guidelines. For example, records showed people's medication had not always been counter signed by a second member of staff as per national guidelines. The team leader told us that she has raised this with staff on numerous occasions, but staff had not listened. Other records showed they had not been updated when medicines had been returned as no longer required. This meant staff did not know what medicines were being kept. We carried out a stock check of medicines, however and found that stock levels held were correct.
● People received support to manage their 'as required' medicines. Protocols and procedures were in place for staff, so they knew how to respond to people and administer their medicines appropriately.

Systems and processes to safeguard people from the risk of abuse
● Staff were not always able to tell us if they had received training on safeguarding people from harm. However, they told us they knew how to recognise and protect people from the risk of abuse. Staff knew how to report any safeguarding concerns, within the service, and externally.
● The registered manager and provider were aware of their responsibility in reporting any concerns and knew how to contact the local safeguarding authority.

Preventing and controlling infection
● Staff were not always able to confirm if they had received training, however told us they understood what they need to do to prevent the spread of healthcare related infections.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means that 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 inadequate. At this inspection, this key question has remained the same, 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.

At our last inspection, the provider had failed to provide effective oversight of the service and ensure the service delivered was of good quality; they did not have systems in place to identify what was working well and what needed to improve. There was a continued lack of improvement and sustainability. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found not enough improvement had been made and the provider continued to be in breach of Regulation 17.

Continuous learning and improving care; 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.

- We continued to have concerns about the provider's oversight and the management of the service. Insufficient action was taken to fully address concerns, continuously learn and drive improvement.
- Investigations and subsequent dismissals of staff, carried out by management, did not identify and address root cause to drive improvement and prevent further safeguarding incidents. Whilst outcomes recognised poor or inappropriate support, staff training, support and supervision provided to staff and its effectiveness, was not considered or reviewed.
- Staff did not receive regular, planned and structured supervision to support them and reflect on their day-to-day practice, and professional development. The provider did not have systems in place to follow up on new staff progress and there was a lack of overview to identify knowledge gaps, training needs and assess understanding and competency. This did not give staff opportunity or support to ensure they were competent to meet people's needs safely. A staff member had received only one supervision during the four months of their employment at the service, despite having no previous experience of working with people with a learning disability or autism.
- Support for staff learning and development was insufficient. Staff had not received the training they needed to give them the skills to support people safely and in line with best practice. A staff member told us they had not received any training to enable them to support people effectively. They said, "I have been here nearly four months and I have been put on a day's training tomorrow." Another staff member told us, "When I started, I was told I was supposed to be starting the Care Certificate, but this hasn't materialised." They said their induction consisted of an overview of all mandatory subjects over a few days, shadowing a few times and reading care plans.
- Systems for managing staff training was ineffective. The training programme and some training

certificates were incorrect and stated staff had received training they had not. A staff member told us, "I have told [the registered manager] and [the training manager] that the training matrix is not accurate, and I have not received all the training it says I have." Staff told us they had been requesting training to help them in their role but it had not been forthcoming and supervision records confirmed this.

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

● Since our last inspection, the provider informed us they were closing the service because of 'the level of risk under which people were living' due to the 'dysfunctional' staff culture that was 'resistant' and 'embedded'. Subsequently permanent staff had left or were leaving and there was a heavy reliance on temporary staff with basic training. We informed the local authority of our concerns. The local authority was working with people and their families towards a safe move into suitable alternative services.
● The registered manager told us they had tried to improve the culture of the service and staff attitude, however there was no evidence to show how this was being done. They told us there was now a deputy working with specific people and they and the new training manager had made, "a presence on the floor." Staff told us the registered manager was not visible. One said, "I do not know what [registered manager] does, sometimes I do not know if [registered manager] is here or not." Another staff member told us, "[The registered manager] has not made any effort to get to know the people living here or staff; they still call me by the wrong name." A third said, "Some days we don't see [registered manager] at all; they go into the office and don't come out."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● There were widespread and significant shortfalls in the way the service was led and the governance in place did not assure delivery of high quality and safe care. The provider did not have robust and sustainable audit and monitoring systems to ensure the quality of care was consistently assessed, monitored and improved
● Staff were unclear about the expectation of their roles and responsibilities; morale was very low and they felt let down. There was no effective leadership to oversee and direct staff on each shift. Staff told us the service was poorly led and they felt very unsupported. One staff member told us they were given responsibilities above their role without any support, they said, "We had staff that thought they could do anything because there is no shift oversight or leadership." Another told us, "I feel this situation could have been avoided, we have not had effective management or support from the company to try and make this work."
● The provider did not have a robust action plan for management and staff to work towards and drive improvement.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Stakeholders and healthcare professionals had not been contacted to ascertain their views on the quality and safety of the service.
● Relatives were not engaged with regards to the running of the service but there was contact with relatives during care plan reviews and informally during visits.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who use services and others continued to not be protected against the risks associated with unsafe or unsuitable premises

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to provide effective oversight of the service and ensure the service delivered was of good quality

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of skilled and competent staff to keep people safe and meet their needs.