Consensa Care Limited

Consensa Care Limited - Highbury Gardens

Inspection Report

Consensa Care Ltd- Highbury Gardens,
67-69 Highbury Gardens,
Ilford, Essex IG3 8AF.
Tel: 020 8551 0030
Website: www.consensacare.com

Date of inspection visit: 9 January 2015
Date of publication: 01/06/2015

Contents

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 9 April 2014. A breach of legal requirements was found. As a result we undertook a focused inspection on 19 January 2015 to follow up on whether action had been taken to deal with the breach.

You can read a summary of our findings from both inspections below.

Comprehensive Inspection of 9 April 2014.

Consensa Care Ltd - Highbury Gardens provides personal care and accommodation for up to six people with a dual diagnosis of mental health and substance abuse needs. People who use the service may neglect their basic needs and place themselves at risk of harm. The service aims to support people with their health needs whilst providing a safe and stable living environment. It is based in a large house with a garden in a residential area. Each person had their own room and the use of shared communal areas. The condition of the home was checked during the inspection and it was clean and well maintained.

At the time of the inspection, the manager of the home, who has been in post since July 2013, was not registered with the Care Quality Commission (CQC). The provider told us the current manager was due to apply to the CQC for registration. The Commission is keeping the situation under review and will take further action if necessary to ensure the service has a registered manager.

During the inspection we spoke with all five of the people who lived at the home. They told us the service had helped them. For example, one person said they enjoyed living in the home. They told us that they were supported to follow their interests. They said, "I have been here a good few years and have done some good art work whilst here. I feel calm." Another person's social worker had written to the home stating, "I have been greatly impressed by your long-standing commitment to X's care and dealing with the challenges they present."

People and the community mental health teams who supported them were involved by the home in the process of planning support to meet their individual needs and preferences. Each person's support plan explained how staff supported them to keep healthy and safe and to undertake activities of their choice. People told us they had regular meetings with a support worker which helped them. One person said, "I can raise any issue at all with my key worker."

Some people told us that they found living in the home 'boring' and said they did not get enough assistance to improve their quality of life through involvement in worthwhile activities. People's records showed that staff had worked with them to encourage them to choose and undertake activities such as going to the gym and the library. However, people had not always continued with their chosen activities. People told us they had ambitions to find work. For example, one person said they wished to be a bricklayer. These long term goals were not reflected in people's support plans.

During the inspection all the people who used the service went in and out of the home as they wished. They told us they were free to come and go at all times. One person said, "I do what I want to do. The staff cannot stop me." There were no restrictions on people that came within the scope of the Deprivation of Liberty Safeguards.

People told us they felt safe most of the time but said that on occasions there were incidents when they had been frightened and had lost personal items. They said staff had dealt well with these situations. Reports showed that the provider had taken appropriate action to recompense and safeguard people when such incidents occurred.

People said they were given support with their medicines. Staff had completed records which showed that people were given appropriate support and they received their medicines safely.

People told us the provider asked them about their views of the service. Notes of meetings confirmed some changes had been made in response to their views. A person told us, "the manager has made a few good improvements."

Staff told us that they thought the way the home was managed had improved since the current manager has been in post. They told us they felt well trained and received good support from their managers. They said they thought there were sufficient staff on duty to meet people's needs safely.

Summary of findings

The provider had made regular visits to the home to speak to people and to ensure staff working to their required standards. This included checks that people's support plans and risk assessments were accurate and up to date.

The provider had a copy of their complaints procedure on the noticeboard. Notes of keyworker sessions and other meetings showed that people's complaints were frequently discussed and they were offered support by staff to make complaints. However, given the number of complaints that people had raised which the provider was aware of, and the fact that no formal complaints from people had been logged, it was evident people had not been effectively supported to make use of the provider's complaints procedure, as required by law.

Additionally, records showed that the Care Quality Commission had not been notified of all the incidents in the home that could affect the health, safety and welfare of people. There was a breach of two health and social care regulations, and the action we have asked the provider to take can be found at the back of this report.

Focused inspection of 19 January 2015

Following our inspection on 9 April 2014 the provider wrote to us to inform us what action they had taken to meet the standards. We undertook this inspection to check that the provider had followed their plans to meet the legal requirements. We found that the provider had followed the plans and that the provider was now compliant with regulations. People who used the service were aware of how to raise a complaint in line with company policy. We also found that the provider had notified the Care Quality Commission of all allegations of abuse and incidents investigated by the police in a timely manner. This meant that the legal requirements were being met.

We found that people were at risk of fire due to unsafe management of smoking in the service. However, the manager had an action plan to address this and we saw that steps had been taken to reduce the risk.

The manager in post at the time of the inspection was not registered with the CQC, however following the inspection the manager has applied for her Disclosure and Barring Service check and was awaiting its return before submitting her application to CQC. We will be monitoring the application process.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

9 April 2014

People who use the service were protected from abuse and avoidable harm. Staff understood their responsibility to take action to safeguard people. People were free to come and go from the home as they wished. There were no restrictions to their liberty.

People told us about some occasions when they had not felt safe. A person said, “I was frightened at the time, but its ok now.” The provider had dealt with these incidents appropriately and taken follow up action to improve people’s safety.

People and their community mental health teams were involved by the service in assessing and reducing risks to people. These had been updated regularly to ensure people were protected from harm.

People received their medicines safely as prescribed. Staff kept accurate medicine administration records, which showed how people had been supported with their medicines.

19 January 2015

People were not safe from the risk of a fire. People smoked in their personal rooms using the floor, window sills and table tops to extinguish their cigarettes.

The home had in place a no smoking policy, however further to the inspection the provider has informed us that they are in the process of amending the smoking policy and liaising with the local fire prevention officer to minimise the risk.

Are services effective?

(Text unchanged from comprehensive inspection)

Are services caring?

(Text unchanged from comprehensive inspection)

Are services responsive to people’s needs?

9 April 2014

People said they had been asked by the provider what they thought about the home. They said some changes had been made in response to their views, which had made them feel more respected by staff.

Summary of findings

People raised some complaints with us during the inspection. However, they had not used the provider's formal complaints procedure. We have asked the provider to ensure people are supported to use this.

19 January 2015

We found that action had been taken to ensure the service was responsive.

The provider had effective systems in place to ensure that people understood who to contact if they wanted to make a complaint and what the processes were after a complaint had been made.

Are services well-led?

9 April 2014

People and staff told us that management arrangements at the home had improved since the current manager took up her post in July 2013. However, at the time of the inspection she had not yet applied for registration with the CQC.

The quality of service people received at the home was regularly checked by the provider. People were supported by sufficient staff with appropriate skills.

The provider had dealt with incidents appropriately but had failed to notify CQC of all serious incidents at the home.

19 January 2015

The provider had regularly informed CQC of all serious incidents and those being investigated by the police. We had received statutory notifications in a timely manner and where appropriate action plans were recorded and implemented.

The home does not have a registered manager in place. A manager is in post however there has been no registered manager since May 2014. At the time of the inspection the provider was interviewing applicants for the position of being registered with the CQC.

Summary of findings

What people who use the service and those that matter to them say

The inspection report contains the findings of two inspections of Highbury Gardens.

Comprehensive inspection 9 April 2014

People had different views about the home. Comments included: “it’s not bad here,” and “the staff are alright.” One person said, “I only live here because I can’t manage on my own.” Another person told us, “I have been to other places and prefer this home as I have a keyworker and I can raise any issue at all with him.”

People said they were unhappy that they could not spend their welfare benefits as they wished. One person said, “it's my money and I just want to be able to spend it as I want.” Another person said, “it makes me feel bad – like I am not trusted.”

People told us they were free to come and go from the home at different times as they liked. One person said, “I like to go out and do my own thing.” Another person showed us their art work and said, “I do a lot of art work. I am cooking lunch today. Staff will help me if I need them to.”

Some people said they were bored. They did not think there were enough activities for them to do and told us they would have like to be given more support to find work or follow their interests. One person said, “I would like to be a bricklayer.” Another person, when asked what a typical day was like, said, "nothingness. Just walking about aimlessly.”

Some people told us that they did not always feel safe from other people in the home. A person said, “sometimes other people can be aggressive. They asked me for money or to use my mobile phone.” They said when this had happened staff had helped them and made them feel safer.

A person who we observed had been verbally aggressive towards the staff said that they were “fed up with the staff threatening to call the police about me.”

People said that they liked most of the staff and the manager. They told us staff were “firm but fair.” They said most of the staff treated them with respect. People said one member of staff sometimes spoke to them inappropriately. We have asked the provider to investigate this further.

People told us that they “each did their own thing about meals”. Some people said they enjoyed cooking and one person told us, “I am making kedgeree for lunch and a few people will have some.”

People said they received help with their health and their medicines and were able to contact health and social a care professionals if they wished. One person said, “I arrange to see the doctor myself and sometimes the staff help me.” People told us they knew how to access an advocate if they needed to. One person regularly met with their advocate and said “I am getting some help from them.”

Two people told us they were involved in reviewing their support but one person said, “they go over my head” and they “do not listen to me.”

Focused inspection 19 January 2015

People told us that they felt safe at Highbury Gardens and that the staff were there to help them. One person told us, "The new manager is good and she always listens to me and helps where she can". Another person told us, "The staff and manager do what they can". We asked people what they liked about living at Highbury Gardens and they told us "You can do what you like here, I can go out or stay in. I can cook and do exercise". We were also told "I'm happy here, I have my own space". People knew how to make complaints. One person said, "I know how to make a complaint and there is a note on the notice board that tells you what to do. I can make a complaint to the manager or the staff, I can go higher if I need to but I don't need to, I have no complaints".

Consensa Care Limited - Highbury Gardens

Detailed findings

Background to this inspection

The inspection report contains the findings of two inspections of Highbury Gardens. We carried out both inspections under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspections checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The first was a comprehensive inspection of all aspects of the service and took place on 9 April 2014. This inspection found the service had breached two regulations. The second inspection which took place on 19 January 2015 and focused on the breaches found and action taken by the provider in relation to the breaches found on 9 April 2014.

Comprehensive inspection 9 April 2014.

Before the inspection, we reviewed the information we held on the home. We asked the provider to complete an information return and we used this to help us decide what areas to focus on during our inspection.

At a previous inspection of the home in April 2013 we found that there was not an effective system in place to monitor the quality of the service people received. In addition, staff were not appropriately supported and supervised. We asked the provider to take action to meet the required standards. When we undertook a follow up inspection in December 2013 we found that improvements had been made. A quality monitoring process was in place and staff received on-going training and supervision.

For this inspection the team consisted of an inspector and an Expert by Experience who had experience of mental health services. We visited the home on 9 April 2014. We spent time observing how people were supported. We looked at all areas of the building and asked a person to show us their room.

During our visit we spoke with all five of the people who used the service. We looked at two people's records and at information relating to staffing levels and staff training and supervision. We checked the arrangements for storing and administering people's medicines. Following our visit we spoke to a person's relative and a health professional who was involved in the care of a person who lived in the home.

Focused inspection of 19 January 2015.

The unannounced focused inspection of Consensa Care - Highbury Gardens took place on 19 January 2015. The inspection was a follow up inspection to check that improvements to meet legal requirements planned by the provider following the 9 April 2014 inspection. The inspection only inspected the service against two of the five questions we ask about the service; is the service responsive and is the service well-led?. We asked these questions because the service was not meeting some relevant legal requirements. The lead inspector for the service carried out the inspection. During the inspection we spoke to four people who used the service, one carer, the manager and the area manager. We looked at the service's policies and procedures, complaints book, complaints form, easy read complaints information, action plans, registration requirements, house meeting minutes, and staff meeting minutes.

Are services safe?

Our findings

Findings from the comprehensive inspection of 9 April 2014.

People told us that staff had advised them how to keep themselves safe when they were in the community and in the home. People said there had been a number of incidents in the home and sometimes they had not felt safe. One person said that they had been a victim of crime and staff had supported them in dealing with the police and getting their money back when their possessions had gone missing. Records showed that the provider had taken appropriate action to safeguard people when such incidents occurred. Incidents had been reported to the local authority in accordance with the organisation's adult safeguarding procedures.

People were protected from abuse and neglect because the provider had taken steps to raise staff awareness of safeguarding issues. Records showed staff had received regular training on this subject. Staff were able to explain to us how they would safeguard people by recognising and reporting abuse in line with the organisation's policies and procedures. They also understood how to raise a concern about their own organisation by reporting it externally by 'whistleblowing'.

People's safety was promoted by the use of close circuit television (CCTV) which recorded activity in communal areas and at the entrance of the building. People told us that they agreed with the CCTV and a person said, "it makes me feel safer." They said they felt their privacy was respected as it did not cover their bedrooms or bathrooms.

Records showed that each person had participated in their individual risk assessment. Their community mental health team had also been involved. People had signed their risk assessments to indicate they agreed with the contents. For each identified risk there was a document which clearly set out 'preventative action', 'control measures' and 'emergency procedures'. It was clear from these how staff should work with the person to reduce a risk and what measures had been put in place to prevent harm and respond to adverse events. For example, there were guidelines in place for the home to follow if a person had misused a substance.

Staff told us there were clear procedures for them to follow when supporting people to manage their money. Records showed that the provider regularly audited cash balances and people's individual accounts. People's money was protected by these arrangements.

Professionals, such as social workers and community psychiatric nurses had arranged for people who used the service to have their welfare benefits managed through the Department of Work and Pensions (DWP) appointeeship scheme. We spoke to a health professional about this. They told us that, in relation to their patient, following an assessment of their mental capacity to manage their finances a 'best interests' decision had been made about how they should be supported. Consequently, when the local authority commissioned the person's support from Consensa Care Ltd - Highbury Gardens, it was arranged that the service would support them to manage their money. It had been decided that the person would receive a set sum each day from their benefit money and would be assisted to budget for items such as clothes.

We observed that some people constantly verbally challenged staff because they wanted to have control of their benefits to spend as they wished. A support worker and the manager respected people's dignity and spoke to them calmly and politely during these interactions. They told us they had received training in working with people with mental health needs and minimising the risk of violence. The provider's training records confirmed this. Staff told us that incidents of verbal aggression towards them were common in the service but there had never been an incident of physical aggression.

People's files showed the service had worked with people's mental health teams to plan how to respond to incidents of challenging behaviour. It was clear from people's records and from our observations during the inspection that this guidance was followed by staff.

We spoke to a person's relative and a health professional who visited the home regularly. They told us they had also observed that people who use the home on occasion displayed behaviour which challenged staff. They said that they thought staff dealt with such incidents professionally and were successful in supporting people to become calmer.

People told us they were free to come and go from the home as they wished. They said staff had never physically

Are services safe?

restrained them. During the inspection all of the people who lived in the home went in and out of the service on their own. People were not subject to any unauthorised deprivation of their liberty.

People were supported by the home to safely receive all their medicines as prescribed. Records demonstrated that the provider had arrangements in place to assess people's needs for support with their medicines and to plan and deliver appropriate assistance. Medicines were kept securely in a locked room and adequate stocks were maintained.

Staff kept a separate medicines administration record (MAR) for each person. We looked at five people's MAR charts these covered the day of the inspection and the previous two weeks. They were well completed and clearly showed whether people had received their medicines or not.

The MAR charts showed that people had sometimes declined to take some of their medicines. In response, staff had taken appropriate action to promote people's health and wellbeing. For example, a person's records showed that staff had discussed with them the implications of them not taking their medicines in terms of the possible effect on their mental health. In addition, staff were in contact with the person's GP and their community mental health team in order to make a contingency plan to prevent an avoidable deterioration in their health.

Some people were prescribed medicines to be taken 'as required'. There was appropriate guidance about this. In each instance, this explained the purpose of the medicine, the safe dose and how it should be administered and recorded. Staff told us they read this information before administering any 'as required' medicines. This ensured people received them in the appropriate circumstances and at the recommended dose.

The provider's training records showed staff had, in relation to the safe administration of people's medicines, received training and an assessment of their skills. Staff confirmed that that they received regular re-training on this subject and had an evaluation of their competence in line with the standards set by the provider. People's MAR charts had only been signed by staff assessed as competent to administer medicines safely.

Findings from the 19 January 2015 focused inspection.

During the inspection we saw four bedrooms and a communal quiet lounge/computer room where people had been smoking despite the home having a no smoking policy and a designated smoking area outside at the rear of the service. We found that people had used window sills, chest of draws and the floor to extinguish their cigarettes posing a potential fire hazard. Whilst the manager could evidence that they had on numerous occasions attempted to encourage people to refrain from smoking through house meetings and discussions, this had been unsuccessful. During the inspection we asked what action the manager would be taking to minimise the risk of fire due to people smoking in the house. We saw evidence that the manager had requested the sensitivity of the fire alarm sensors to be increased, which was being done. We were also told by the area manager that there was currently a review of the homes no smoking policy being undertaken.

Subsequent to the inspection the area manager shared with us their action plan in minimising the risk of fire by, contacting the local fire prevention team to receive further guidance, purchasing additional fire retardant furniture in peoples rooms and offering people online fire prevention training.

Are services effective?

(for example, treatment is effective)

Our findings

(Text unchanged from comprehensive inspection)

Are services caring?

Our findings

(Text unchanged from comprehensive inspection)

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Findings from the comprehensive inspection of 9 April 2014.

People had not been appropriately supported to make a complaint. This was a breach of the relevant legal requirement (Regulation 19(2)(b)) and the action we have asked the provider to take can be found at the back of the report.

The inspection clarified how people's complaints and concerns were responded to. During our visit we observed that staff supported people to act on their concerns. For example, a person was assisted to contact their social worker. A person told us the manager had taken effective action about a concern they raised. They said, "she sorted out my problem and helped me."

The organisation has a complaints process and there was information about it and an advocacy service on the notice board. People raised complaints with us during the inspection but had not used this formal complaints procedure at all. Staff told us that people repeatedly complained to them about some aspects of their support arrangements. People had not been supported to use the organisation's complaints procedure.

People who use the home told us they were asked for their views. A person said "they do ask us about things." The home complied with the principles of the Mental Capacity Act 2005. Staff had received training on this subject and were able to explain to us how to put their knowledge into practice. Records showed people's community mental health teams had been involved in assessing their mental capacity to make decisions and making 'best interests' decisions when people were unable to make a decision themselves. For example, each person's mental capacity to manage their finances had been individually assessed by their community mental health team. These assessments had concluded that people did not have the mental capacity to manage their money without support. Therefore in their 'best interests' the service supported them to manage their money.

There was evidence in a person's records that their mental capacity had been considered in relation to their ability to understand decisions about the management of risks during their day to day activities. We observed that a person carried out some activities unsupervised for example, making a cup of tea, and was assisted by staff when using the oven. This was in accordance with information in their support plan and risk assessments.

The manager held regular meetings with people. Notes showed they were encouraged to be open about their views of the home. Changes had been made in response to people's feedback. For example, metal cutlery was now available for people as they had requested, whereas previously they could only use plastic cutlery. A person said, "this has made us feel much better – not treated like children."

People had a monthly meeting with their key support worker. A person told us they "could raise any issue with their key worker." Records of these meetings mainly consisted of the support worker's account of the person's health and details of what activities the person had undertaken in the past month. Staff had not followed the organisation's suggested draft agenda. This meant people's views of their support were not well documented and did not appear to be a significant part of the keyworker meeting process.

People were assisted to keep in contact with their family and friends. We observed that a person was supported to phone a family member and make a plan to visit them.

Findings from the 19 January 2015 focused inspection.

Three people living at the service were able to tell us who they could contact should they wish to make a complaint. People were aware of what to do should they find they were unhappy with the outcome of their complaint and where to go to seek additional support. They were also able to explain to us that they can access the service's policy and procedure relating to complaints if they wished.

The manager had put an easy read 'How to make a complaint' document on the main hallway noticeboard. The document had both written word and pictorial symbols to show people who used the service how they could make a complaint. The document contained information on external agencies they could contact to make a complaint, for example the Care Quality Commission if they were not satisfied with the response from the service. We examined complaints received since our previous inspection and found these had been recorded and investigated appropriately in line with the

Are services responsive to people's needs?

(for example, to feedback?)

providers complaints procedure. Where people at Highbury Gardens did not speak English as a first language, the home had a system in place whereby they had made contact with an interpreter who they would contact when required. They had also established links in the local community where the person was able to express any concerns on a weekly basis in person or via the phone when required. This would then be relayed to the service who could then address the person's concerns or complaints effectively.

Are services well-led?

Our findings

Findings from the comprehensive inspection of 9 April 2014.

The provider collected information on incidents. Reports showed that effective action to protect people and improve the service had been taken in response to these. For example CCTV had been installed to reduce the risk of people becoming the victim of a crime. However, we found that the CQC had not been informed of two notifiable safeguarding incidents in the past year, although the local authority and the police had been notified and people had been safeguarded. The fact that CQC was not informed meant that there was breach of the relevant legal regulation (Regulation 18(2)(e)(f)). The action we have asked the provider to take can be found at the back of this report.

People in the home told us that management arrangements in the home had improved. A person said, "the manager is good – she is trying to help us." The manager had been in post since July 2013. At the time of the inspection she had not applied to the CQC for registration. The provider advised us that her application will be made as soon as possible. We will keep this under review to ensure an application is submitted.

Improvement plans were in place for the home. Records of the regional manager's supervision of the home manager demonstrated that improving relationships between staff and people who used the home was the key priority. The aim was to ensure people and staff had a calm and positive experience of the home.

The staff group was small and there were regular monthly staff meetings. Records showed that discussions included how to effectively deliver people's support and how best to deal with people's challenging behaviour. Staff told us that communication was good between them and their managers and they were clear about how the provider expected them to support people.

Staff told us and records of their supervision confirmed they were able to raise any issues of concern and there were plans in place to ensure they received appropriate training and development. Staff said that managers were accessible and they could contact them easily at any time for advice and support.

Records confirmed that staff received training when they started work in the home and then at set intervals to ensure their knowledge was up to date. Key topics, such as working with people with mental health and substance abuse needs were included. Staff we spoke with demonstrated a good understanding of people's complex needs.

The regional manager told us that although people who used the service had complex needs, they had mostly lived in the home for some years and their needs were well known to the staff group which was small, well trained and relatively stable. He said this information informed the current staffing levels at the service. During the evenings a support worker worked as a 'lone worker' in the service. Staff told us that they felt that these arrangements were sufficient to meet the needs of people who used the home as they often went out of the home independently. They said in the event of sickness cover was arranged from the provider's staff group or an agency worker who knew the service.

The regional manager frequently visited the home to ensure the quality of the service. Reports of these visits showed he spoke with people in the home and checked support and staff supervision records.

Findings from the 19 January 2015 focused inspection.

Before our visit we checked information we already held about the service. We found that since the previous inspection they had notified CQC of significant events and any allegations of abuse. We discussed this issue with the manager during our inspection who had a good understanding of their responsibility for notifying CQC of any significant events.