Housing & Care 21

Housing & Care 21 - Lea Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected this service on 26 January 2017. This was an announced inspection as we needed to ensure the registered manager and staff were available when we visited the office. At our previous inspection in February 2014, we found that the provider was meeting the required standards we inspected them against.

The service is registered to provide personal care to people in their own homes. At the time of our inspection 15 people were using the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At this inspection, we identified two Regulatory Breaches. You can see what action we told the provider to take at the back of the full version of the report.

Effective systems were not in place to consistently assess, monitor and improve the quality of care.

Medicines were not always administered in a safe manner. Risks to people's health, safety and wellbeing were not always assessed and planned for to ensure people received care that was consistently safe.

Effective systems were not in place to ensure the requirements of the Mental Capacity Act 2005 were followed. People's consent to care was not regularly reviewed to ensure it was still valid.

People's care records did not always contain accurate and up to date information for the staff to follow. This placed people at risk of unsuitable and inconsistent care.

Effective systems were not in place to ensure people's feedback was acted upon to ensure their concerns were acted upon and their care preferences were met.

The registered manager did not always notify us of reportable incidents at the service as required by law.

There were enough staff available to provide people with prompt care and staff were recruited in a manner that protected people from abuse.

Staff knew how to identify and report potential abuse and they received training to enable them to carry out their role of delivering care.

People were supported to eat and drink in accordance with their care preferences.

People were supported to access health and medical support when required.

People's privacy and dignity was promoted and staff treated people with kindness and respect.

Formal complaints were managed in accordance with the provider's complaints policy.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. Effective systems were not in place to ensure that people's prescribed medicines were administered safely.

Risks to people's health, safety and wellbeing were not always assessed, planned for or managed in a manner that promoted safe and consistent care.

Safe staffing levels were maintained and staff were recruited in a safe manner that protected people from the risk of avoidable harm.

Staff knew how to identify and report potential abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective. Improvements were needed to ensure that people's consent and ability to consent were regularly assessed and reviewed.

People were supported to access health care professionals when needed.

Staff received training to provide them with the knowledge and skills needed to meet people's needs.

Is the service caring?

Good

The service was caring. People were treated with kindness and respect.

Privacy and dignity was promoted and people were enabled to make decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Effective systems were not in place to ensure feedback from care reviews was acted upon to ensure people's changing care preferences were met.

Care records did not always contain accurate and up to date information for the staff to follow. This placed people at risk of unsuitable and inconsistent care.

A complaints system was in place and was followed. The registered manager had identified that some low level concerns were not being recorded to show the action taken to address them.

Is the service well-led?

Requires Improvement 

The service was not consistently well-led. Effective systems were not in place to asses, monitor and improve the quality of care.

The registered manager did not notify us of all reportable incidents as required by law.

People found the management team helpful, but someone people did not know who the registered manager was.

Housing & Care 21 - Lea Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an announced inspection of Housing & Care 21 - Lea Court on 26 January 2017. We gave the provider 24 hours' notice as we needed to ensure the registered manager and staff were available when we visited the office.

We inspected the service against the five questions we ask about services: is the service safe, effective, caring, responsive and well-led? Our inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using, or caring for someone who uses this type of service.

We checked the information we held about the service and provider. This included the statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. We used this information to formulate our inspection plan.

We spoke with four people who used the service and a person who visited the service. We spoke with three members of care staff, a team leader and the registered manager. We did this to gain people's views about the care and to check that standards of care were being met.

We looked at the care records of four people who used the service, to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included staff files, rotas and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

People told us they received their medicines when they needed them. One person said, "They come in and give me my tablets everyday". However, care records showed that medicines were not always given in a safe manner. For example, one person's medicines records showed that on three occasions over a one month period, staff had administered too much of their prescribed pain relief medicine within a set time. We could not identify if any harm had been caused to this person as a result of this. However, administering medicines in this unsafe manner placed the person at risk of harm to their health.

People's medicines records also showed that their medicines were not always given as prescribed as they were not always available in people's homes. For example, we saw that two people's prescribed pain relief could not be given consistently as prescribed as there were occasions where this medicine was not available to administer as it was not always in stock in people's homes. We were unable to identify if people had experienced pain as a result of this. The registered manager told us it was the responsibility of people's relatives to ensure medicines were available. However, care records did not always show that people's relatives had been contacted in a timely manner to ensure people's medicines were readily available.

People told us that staff supported them to stay safe. One person said, "Having the carers here to support me when I have a shower and get dressed and undressed makes me feel so much safer and my confidence has come back". We found that some risks to people's health, safety and wellbeing had been assessed and planned for. However, improvements were needed to ensure that all significant risks posed to people had been assessed and planned for, to ensure people received safe and consistent care. For example, the risks associated with a person being supported to bathe using specialist equipment had not been formally assessed and planned for. The staff we spoke with told us how they supported this person with this task in a safe manner. However, any new or temporary staff would not have access to the information required to support this person with this task in a safe and consistent manner. This meant the person was at risk of receiving unsafe and inconsistent care.

People told us that the staff regularly visited them on time. One person said, "They are always very prompt". Another person said, "They are always on time". Staff confirmed and care records also showed that people received their care as planned. This showed that adequate staffing levels were maintained to ensure people received their planned care at the agreed time. The registered manager told us the staffing levels were regularly reviewed and changed to meet people's changing care needs.

People told us that they felt safe receiving care from the staff. One person said, "Yes, I feel safe around the carers. They treat me well". A visitor told us that their relative was, "Definitely safe here". Staff told us and we saw that recruitment checks were in place to ensure staff were suitable to work at the service. These checks included requesting and checking references of the staffs' characters and their suitability to work with the people who used the service.

We found that people were protected from the risk of abuse. Staff explained how they would recognise and report abuse. One staff member said, "I'm not afraid to speak up for service users". Procedures were in place

that ensured concerns about people's safety were appropriately reported to the management team and the local authorities safeguarding team. We saw that these procedures were followed when required.

Requires Improvement

Is the service effective?

Our findings

People told us that their consent to their everyday care was sought before the staff assisted them with their care needs. One person said, "They usually ask me how I'm feeling and if I'm ready to make a start". Care records showed that people had formally signed to consent to certain parts of their care. For example, consent forms were in place to show that people had consented to staff sharing information about their care with other professionals if needed. However, people's consent to these parts of their care was not regularly reviewed to ensure people understood what they were consenting to and to identify if they still consented. For example, one person's consent to share information with other professionals was dated 2015 and had not been formally reviewed since this date to check that the person still consented to this part of their care. This meant that improvements were needed to ensure people's consent to their care was regularly reviewed.

Staff told us that one person who used the service was frequently confused and disorientated to time. The registered manager told us that at times, this person's ability to make decisions about their care may have been affected by their confusion. 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. This person's care records contained no evidence of a mental capacity assessment to show that the registered manager had assessed and considered their ability to consent to the care they received. The registered manager confirmed that no assessment had been completed. This showed that improvements were needed to ensure the requirements of the MCA were followed.

Most staff demonstrated they understood the basic principles of the MCA. However, they told us they would refer to people's care records to check if people had capacity to make decisions about their care. Because the care records contained no information about people's mental capacity, staff would not be able to find out information about people's mental capacity. The registered manager told us that a new assessment form had recently been introduced at the service to enable mental capacity assessments to be completed. We will check that this form has been effective at our next inspection.

People told us that they were supported to eat and drink in accordance with their care preferences and needs. One person said, "The carer will usually read me out a list to remind me what I've got and then she will cook it for me. I always have plenty to drink". Another person said, "They never mind making me anything. It just depends on what I fancy". Care records confirmed that people received support to eat and drink if this was planned for and required.

People told us that staff helped to arrange appointments with health care professionals when needed. This included appointments with doctors and nurses. Staff and care records also confirmed this and we saw people were also supported to receive emergency medical intervention when this was required.

People told us they had confidence in the staff and staff told us they received training to give them the knowledge and skills required to meet people's care needs. For example, one staff member told us their first aid training had enabled them to keep a person safe following a medical emergency. They said, "I knew what to do and I was able to put them into the recovery position". Training records confirmed that staff received the training they needed to meet people's care needs.

Good

Is the service caring?

Our findings

People told us that the staff treated them with kindness and respect. One person said, "They treat me very well". Another person said, "I'm very house proud, but they are good and they respect my belongings and look after them as I have asked them to". Staff told us they enjoyed working at the service because they liked spending time with the people they supported. One staff member said, "Everyone I care for is really nice". Another person said, "I love the people here".

People told us that they felt relaxed around the staff and were able to approach them with ease to ask for additional support when needed. One person said, "If I've ever asked them to do anything extra, they have never made a fuss and they make you feel alright about asking". Another person said, "They never mind doing extra jobs as well if I'm not feeling up to it, like making the bed or putting some washing in for me".

People told us that their care was provided in a dignified manner. For example, one person told us how staff encouraged them to be as independent as they could be which was important to them. They said, "When I need help, it's available and when I can and want to be independent, I can do that as well. I get the best of both worlds". Staff gave us examples of how they promoted people's dignity. For example, one staff member said, "When I'm helping people to wash I always close doors and cover people with a towel to make them feel more comfortable".

People told us that the staff knew their likes and care preferences. For example one person said, "They all know what I like and don't like". People also confirmed that staff provided care in accordance with their preferences. One person said, "I am quite fussy in my old age, but they are good and do things how I like them to be done". Another person said, "They know I like to do things in a certain order every morning". This showed the staff knew and met people's individual care preferences.

People told us their privacy was promoted. One person said, "If I don't hear them at the door, they always shout hello to warn me that they are here". Staff confirmed that they respected people's right to privacy. One staff member said, "Even though we have keys to people's flats I always knock and ring the doorbell first. I then say hello when I go in in case they didn't hear me come in".

People confirmed they were involved in making choices about their care. For example, people told us that staff asked them what clothes they would like to wear and what meals they would like to eat.

Requires Improvement

Is the service responsive?

Our findings

People told us and care records showed that they were involved in the assessment and review of their care. One person said, "I remember talking to someone about what help I needed when I first moved in". A visitor said, "It wasn't too long ago when the manager and another carer invited me to a review". However, we found that improvements were needed to ensure feedback from care reviews was consistently acted upon in an effective and responsive manner. One person told us and their care records showed that they had asked for the timing of one of their care calls to be changed to suit their personal preference. We saw that this change had not yet been accommodated, so we asked the team leader when this change would be made. They told us that as soon as a call slot became available at the person's preferred time this change would be made. We asked where they recorded this information to ensure that this person's request would be met. They said they had made a mental note of this person's request and because they allocated the call times, they would remember this person's request when they planned the rotas. The team leader confirmed that people's requests for time changes were not recorded in a central place for all staff to be able to access in the event of any unplanned absences which may have meant they were unavailable to plan the rotas. This meant there was a risk that this person's care preferences in regards to the timing of their care calls would not be met. In response to our feedback, the registered manager acknowledged that this was an area for improvement and they suggested that a central recording system was implemented. We will check the effectiveness of this at our next inspection.

People told us that staff were responsive to their individual care needs and preferences. However, one person's care review records showed they had fed back to a senior staff member that one member of care staff required more prompting when they supported them than other care staff did. People's care records were not always accurate or up to date, so staff did not always have access to the information they needed to meet people's needs in a safe and consistent manner. For example, one person's care records stated they had a medical device to help manage their continence needs. Their care records stated that this device needed to be checked during each care call. The staff we spoke with told us this medical device was no longer in place and hadn't been in place for some time. This meant the person's care records did not reflect their changing continence needs. This placed this person at risk of receiving unsuitable and inconsistent care and support from any new or temporary staff, as the information these staff would need to meet this person's continence needs was not recorded.

People told us they knew how to complain. One person said, "I know how to complain because I was given a leaflet about it when I moved in". Another person said, "I think I've seen something about it in my folder" and, "I certainly would tell someone if I wasn't happy". Complaints records showed no formal complaints had been made about care. The registered manager had identified that low level concerns were not recorded by staff to capture the concerns and the action taken to address them. A new system was due to be implemented to record this information. We will check its effectiveness at our next inspection.

Requires Improvement

Is the service well-led?

Our findings

We found that the systems in place to assess, monitor and improve quality were not always effective. For example, regular medicines audits were completed by staff and the registered manager. Two of the medicines audits we looked at had been completed by a staff member and then checked for quality by the registered manager or another member of the management team. Both of these completed audits had failed to identify that the medicines records showed that the person had received too much of their prescribed pain medicines. This meant the quality checks had not identified the unsafe administration of this person's pain relief and the risk of harm it posed to the person's health and wellbeing.

The registered manager told us that no systems were in place to check the content of the information in people's care records. This meant that the registered manager had not identified that the information in some people's care records was not accurate or up to date. For example, they had not identified that one person's care records did not contain accurate and up to date information about their continence needs. This placed the person at risk of receiving unsuitable and inconsistent care.

We found that action was not always taken to ensure people's risks were reviewed following safety incidents. For example, one person's care records showed they had fallen on one occasion in 2016. This fall did not trigger a review of their falls risk assessment and no risk management plan was in place to reduce the risk of further falls from occurring. The registered manager acknowledged that this person's falls risk assessment should have been reviewed following the fall. This meant that appropriate action was not always taken to promote people's safety and protect them from avoidable harm.

The information on the incident log maintained by the registered manager did not match the incident information in people's care records. For example the number of falls that people who used the service experienced were not all recorded on the manager's incident log. This meant effective analysis of incidents to identify patterns and themes to prevent harm or injury could not be completed.

Feedback from people about their care was sought through the completion of a satisfaction questionnaire. The last survey was completed in September 2016. However, this feedback was not analysed and used to improve people's care experiences. Some people had raised concerns or come up with ideas for improvements. For example, one person had suggested new staff needed more training to ensure they understood the practical problems associated with using a wheelchair. We asked the registered manager if they had analysed and acted upon this feedback. They confirmed they had not and said, "I'm under the impression head office deals with this". This meant effective systems were not in place to act upon people's feedback and improve people's care experiences.

Most staff described the registered manager as 'approachable'. However, some staff felt the registered manager was not always responsive to concerns. Comments from staff included, "Some things fall on deaf ears", "We do have to keep on and on before they act on something" and, "It needs a bit more leading". An example given to us by staff on issues not acted upon included; changes to care plans not being made, which we had also identified as a concern as care records were not always accurate and up to date. This

meant that staff were not confident that their feedback would be acted upon in a prompt manner to improve the quality of care.

Some staff told us that they did not have regular meetings with the management team or senior staff to assess and review their development needs. One staff member said, "I can't remember the last time I had supervision, I think it was over a year ago". Another staff member said, "I might have had one supervision in the last year". All staff told us they had not had an annual appraisal to formally assess and plan their development needs. The registered manager told us that regular supervisions were completed. However, they were unable to evidence this as staff records did not confirm that these supervisions took place as planned. This meant we could not be assured that the development needs of the staff were being regular assessed and planned for.

The above evidence shows that effective systems were not in place to assess, monitor and improve the quality of care at the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that a new electronic monitoring system was being implemented at the service. They told us this system would help address some of the concerns identified at our inspection as the system included; incident analysis, care plan audits and staff performance monitoring. We will check the effectiveness of this system at our next inspection.

The registered manager had not notified us of reportable incidents at the service as required by law. We found that two incidents of alleged abuse had been reported to the local authority under safeguarding reporting systems. However, the registered manager confirmed that they had not notified us about these two incidents as required under our registration Regulations. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People described the management team as, "Friendly and helpful" and, "Most welcoming". However, some people were unsure about who the registered manager was. The registered manager had identified this as an issue and was planning to place photos of the staff team at the service, so people could identify which roles each staff member had. They also planned to make themselves more accessible to people by rearranging their office.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager had not notified us of reportable incidents at the service as required by law.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not in place to assess, monitor and improve the quality of care at the service.