Housing & Care 21

Housing & Care 21 - Cedar Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an unannounced focused inspection of Housing & Care 21 - Cedar Court on 19 and 20 July 2018. This inspection was done due to concerns we had received about the service. We inspected the service against two of the five questions we ask about services: is the service safe and; is the service well led. This is because of concerns that the service was not meeting some legal requirements.

No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

Housing 21 Cedar Court provides personal care and support for up to 40 people aged 55 and over. At the time of inspection, 37 people were using the service and one person was in hospital. This service provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented, and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

Accommodation is located over three floors, which is wheelchair accessible with lift access to all floors. There are communal areas, solely for the use of people living at Cedar Court, including a living room and quiet room on the first floor. Care staff are available on-site 24-hours a day.

At this inspection, we found that people had not always received safe and appropriate care. Staffing levels were not sufficient to meet people's needs. Risk assessments and management plans were in place. However, these were not always reviewed and updated in a timely manner to ensure staff provided care in a safe manner. Staff did not support a person to transfer safely from a chair to a wheelchair.

There was no registered manager. The previous manager left the service in May 2018. A manager had been appointed and would be applying for registration with the Care Quality Commission. 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 2008 and associated Regulations about how the service is run.

People received the support they required to take their medicines. Medicine errors were identified and resolved.

Staff understood the safeguarding procedures to follow to identify and report abuse. Accidents and incidents were reported and action taken to minimise the risk of a recurrence. People received care from

staff deemed suitable to provide support. Staff followed good infection control and prevention practices.

Staff morale and teamwork varied amongst team members. The provider had restructured the service and had put plans in place to support staff. Staff had started to see the benefits of the management's intervention in building a cohesive staff team. However, it was too early to see how consistent and embedded the new culture will be. Some staff felt unable to approach the managers and highlighted some disharmony within the team. Some staff felt unsupported in their roles and were not confident their concerns were taken seriously. People using the service did not feel comfortable naming staff where there were concerns.

The provider worked with other agencies to deliver high standards of care. Audits were carried out on the quality of the service. Improvements were carried out although some shortfalls were not always identified and/or acted on.

We found two breaches of regulation relating to safe care and treatment and staffing. You can see what action we told the provider to take at the back of the full version 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?

Requires Improvement

Aspects of the service were not safe. The provider had not ensured there were always sufficient staff on duty to meet people's needs safely. This could put people at risk of receiving unsafe care.

Risks to people's health and well-being were identified and managed. However, some risk assessments had not been reviewed and updated to reflect the changes in people's health and well-being. Staff knew how to identify and report abuse to protect people from harm.

Staff were trained to administer people's medicines.

People were supported by staff who underwent appropriate recruitment procedures. Staff knew how to minimise the risk of cross infection.

Is the service well-led?

Requires Improvement

The service was not always well-led. There was no registered manager at the service as required by law. The lack of a consistent registered manager resulted in a lack of oversight on staff morale, training and development and provision of care.

A new manager was in post who was going to apply for registration with the Care Quality Commission (CQC).

The provider had taken steps to improve staff relations and teamwork. However, a culture of mistrust amongst some staff and management persisted.

The quality of care underwent regular audit and checks. Improvements were made although these were not always done in a timely manner.

Staff worked with other agencies to deliver care.

Housing & Care 21 - Cedar 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 is 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.

The inspection was prompted in part by a whistleblowing notification received by the Care Quality Commission (CQC). The information shared with CQC indicated potential concerns about care provision, staffing issues and day to day management of the service. This inspection examined and followed up on these issues.

Prior to the inspection, we had brought the whistleblowing concerns to the attention of the local authority who commissioned the care of people using the service. We also reviewed the information we held about the service including any statutory notifications received. A statutory notification is information about important events which the provider is required to send us by law. We used this information to help us plan the inspection.

This inspection took place on 19 and 20 July 2018 and was unannounced. The 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 care service.

Inspection site visit activity started on 19 July and ended on 20 July 2018. We visited the office location on 19 and 20 July 2018 to see the manager and office staff and to review care records and policies and procedures. The expert by experience attended the second day of the site inspection visit. We made telephone calls to four relatives of people using the service on 20 and 23 July 2018 to gather their views about the service.

During our inspection, we spoke with six people using the service. We spoke with seven members of care

staff, an assistant manager, the manager and an extra care regional director. We spoke with two health and social care professionals who were visiting people using the service.

We looked at 11 care records and six medicines administration record charts. We read management records of the service including incident reports, medicines management processes, safeguarding concerns, complaints and audits to monitor the quality of the service. We viewed six staff records relating to training, supervision and appraisal records. We checked feedback the service had received from people using the service and their relatives.

Requires Improvement

Is the service safe?

Our findings

People had mixed views about their safety at the service. Comments included, "Oh yes feel really safe here. I'm quite happy", "I'm happy because I get on with all of them", "They come quickly [in response to call bells]", "I don't like some of them [staff] because they don't want to do much for you. It's not my fault I can't lift my legs, it's not nice", "It makes me feel sad [staff] not helping", "Five times out of seven staff do not help me", "One carer shouted at me but she doesn't shout at me anymore she talks to me. She shouted because I couldn't do what she wanted me to do because my left side doesn't work", "Some of them not very nice you ask them to lift your leg up into the bed and say no we are not allowed to" and "The only answer they only give me is 'not allowed'. It's the getting in and out of bed that does me." Comments from relatives of people using the service included, "Staff turn up promptly as they can once [person] presses the button", "On the whole I feel she is safer here than at home alone. You expect a certain level of standard and service. Certain [members of staff] don't do their job properly and show attitude to family", "I have been in contact with social services about the care he/she is receiving. There are times where we feel certain things have slipped on the care procedures they are following. We are not sure every care worker is aware of what needs to be done" and "The attitude of some of the staff needs to be addressed and monitored."

Six of the eight people using the service spoke negatively about the number of staff available to meet their needs. Comments included, "I think there is enough", "They [staff] haven't got a lot of time. They rush me", "It depends on who is on duty", "They can't always come quickly they have told us that. Sometimes up to 40 minutes, the thing is I need to go to the toilet", "They could do with a bit more sometimes I have to wait ages", "One night I had to wait for four hours as I am not allowed to get out of the chair. I'm not safe, I'll fall", "I have breakfast at 8 o'clock. They don't clear the breakfast things until lunchtime." One relative commented, "I get the impression there is fewer staff than years gone by. Quite a few occasions they are late for breakfast. My feeling, they are understaffed." Another relative commented, "There is one thing that is endemic, high staff turnover, consistently understaffed. The times they're meant to come lapse consistently, very rarely do you get care staff that get to know the foibles. Invariably less than a year a handful that she knows but she copes with new staff coming in and out." A third relative commented, "They rush with her. They need to get a full quota of staff." A health and social care professional commented, "I find that staff spend time with people. They help with what they need. My client's health has improved since she moved into Cedar Court."

Staff also confirmed they felt there were issues with staffing levels at the service. While staff commented that they supported people as required, they expressed that there were ongoing issues with demands placed on their time. One member of staff told us, "Sometimes it's fine and sometimes we are really short." Another member of staff said, "We usually go over the allocated time by at least 30 minutes for one or two clients. You can't rush the person." All the staff we interviewed talked about how they went over their allocated time when supporting three named people. Staff told us this sometimes caused them delays in providing care to other people. They told us they explained to people if they were running late for their calls. We observed on entering one flat at 11 o'clock, a bowl of congealed porridge and an empty cup in front of the person. When a member of staff entered the flat they removed the items and put them in the sink to soak.

The manager reviewed people's needs and worked with the service commissioners to increase the time allocated for care delivery. However, this had not always been done in a timely manner which resulted in staff feeling the pressure to complete tasks. This was notable in the case of one person using the service who all staff mentioned in our discussions. We highlighted this to the manager who told us they continued to work with the service commissioners. There was a system in place for staff to record if they went over the allocated time for monitoring purposes and for the service commissioners to use when reviewing the care package. Not all members of staff maintained records of this. We read one care plan where staff had maintained such records and had been given additional hours to deliver care.

The manager determined staffing levels through assessing people's needs and the support each person required. Rotas were planned, although some shifts were not covered. Rotas showed that some members of staff worked over 50 hours a week, with some having minimal shifts and requesting more work. Records showed two members of staff who had requested to be paid for their annual leave days which they were unable to take because of the workload. We asked the manager if this had an impact on care delivery and covering of shifts. The manager explained that the issue was being addressed as the organisation had gone through a restructure and now staff had contracts that guaranteed them specific hours each week. On both days of our inspection, the rota was not covered. The manager told us this was due to last minute cancellations by staff. Staff told us the assistant managers shared the workload if the rota was not covered.

We could not be confident people received the support they required or wished for because there were insufficient members of staff available to support them.

The provider had not ensured there were sufficient staff to meet people's needs safely. These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care delivery took into account risks to their safety and well-being. One person told us, "They [staff] do use the hoist sometimes, normally two carers at a time." Health and social care professionals were involved in risk assessment and management plans to determine ways of supporting people safely. Care records contained risk assessments for aspects of people's care such as mobility, personal care, environment, eating and drinking and falls. Eight of the 11 care plans contained sufficient details and guidance for staff on how to deliver care safely.

We observed two members of staff supporting a person with a transfer from a chair to a wheelchair. One member of staff brought in a hoist that had not been charged. This meant the staff could not carry out the task as safely as risk assessed. The two members of staff tried to support the person to move without the aid of the hoist. The process which took over 25 minutes left the person disconcerted. We reviewed the person's care plan. The risk assessment clearly stated the hoist had to be charged in readiness for any moving and handling tasks. Although staff were able to describe risks to the person's health and well-being and the support they required, the care plan did not reflect changes in the person's needs. The staff told us they had been advised that they could support the person without using a hoist. The person's falls risk assessment did not indicate options available when staff did not have a hoist and how to mitigate risks. This could pose a risk to people using the service and staff. We informed the manager of our observations who informed us they would be reviewing and updating risk assessment and management plans to reflect the support each person required.

We raised the issue with the manager because we were concerned that the person could be harmed from unsafe moving and handling practices.

The above constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

People were supported by staff who were recruited in a safe and appropriate manner. The provider carried out pre-employment checks which included applicants completing an application form and attending interviews. Staff provided proof of identity, right to work in the UK and underwent a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. Satisfactory checks including references and explanations of employment gaps were obtained, before new staff started to work at the service. New staff completed a mandatory probationary period to ensure they were fit for their roles before they were confirmed in post.

Plans were in place to support people to evacuate the building in the event of an emergency. Each person had a Personal Emergency Evacuation Plan (PEEP) in place that contained sufficient detail about the support they required to be safely evacuated.

People were supported to keep safe from abuse. Staff knew how to recognise and report abuse. One member of staff told us, "It's our duty to prevent people getting harmed." Another member of staff said, "I would report any abuse or poor practice to the manager." Staff understood the safeguarding procedures on how to protect people from abuse. Safeguarding concerns were reported to the local authority for investigation. Staff attended training and received refresher courses in safeguarding adults to keep their knowledge up to date about how to protect people from abuse.

Staff followed procedures in managing incidents to ensure people were safe from avoidable harm. Incidents and accidents were recorded and reported to the manager. Audits were carried out to identify patterns and trends. However, staff spoken to were not aware of some incidents that had happened at the service. Whilst managers discussed these with individual staff, we did not see any evidence of how the team benefitted from any learning from incidents that occurred at the service. Appropriate procedures and systems were in place to record and monitor incidents and accidents. The provider had a contingency plan to minimise disruption to the service in the event of adverse weather or severe staff shortages.

People were supported to manage their finances when needed. Appointeeships were in place when required to support people who did not have the capacity to manage their finances. Staff maintained records of how they spent people's finances and kept accurate receipts of income and expenses. Audits were carried out on the transactions to minimise the risk of financial abuse. Incidents involving loss of people's finances had been investigated and resolved. The provider had reviewed the systems to reduce the risk of loss of people's finances.

People lived in premises that were maintained. Checks on equipment, gas and electrical appliances were carried out to ensure these were safe for people to use. Regular audits of premises, fire doors emergency lighting and exits were undertaken and there were no concerns identified in the last report. Legionella tests showed water sources were safe for people to use. Floors were maintained and free from hazards and trips.

People received care in a manner that minimised the risk of infection. Staff understood the importance of infection control and prevention. Staff told us they followed good handwashing procedures, wore personal protective equipment (PPE) and used hand wash liquid and paper towels. Domestic staff had cleaning schedules which they followed to ensure premises, floors and surfaces were cleaned and disinfected.

People received the support they required to take their medicines. One person told us, "I take my own medication. [Staff] remind me to take it." A relative said, "They [administer medicines] regularly it's all

logged and signed for." Each person had a medicine administration record (MAR) which showed the medicines they were on, dosage and frequency. Staff had completed MARs and we did not identify any gaps in signing. However, there had been medicine errors which had been resolved. The manager had supported the staff who made medicine errors through retraining and discussions about good practice. GPs were involved in reviewing people's regular and 'when required' (PRN) medicines to ensure that these remained appropriate for each person's needs. Checks and audits were carried out regularly to monitor the safe administering and management of people's medicines. Staff received medicines management training and underwent a competency assessment. Staff had access to the provider's medicines policy for guidance.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager as required by the condition of the provider's registration with the Care Quality Commission (CQC). Adequate arrangements had been made to provide management cover. However, people using the service, their relatives and staff found the changes disconcerting. The provider had arranged for senior manager's to support staff in the absence of a registered manager and retained oversight of the management of the service. Staff knew that there was a new manager and told us that they hoped she would stay at the service to allow for continuity and reliable support. The manager told us that although she was new in post, she had felt supported in her role and could contact other managers in other schemes managed by the provider and the head office for guidance when needed. The lack of a registered manager and changes in management affected the monitoring and follow up on staff training, effective supervision and learning from incidents and accidents. The provider submitted notifications to the CQC as required.

People using the service, their relatives and staff expressed concerns about the management of the service. Comments made included, "Slight failings with the follow through, hard due to the change of managers", "Standards have slipped due to staff turnover and not having managers in place", "They have had a massive turnover of managers in the last two years. Managers have come and gone", "Quite a few times managers don't know what they are doing. They come and go" and "I have tried to raise things with previous managers then they leave. The churn is too much impact on the level of service." Staff told us they got on with their work and were prepared to work with any managers appointed to work at the service. People's concerns highlighted that management changes had affected care delivery.

There was a culture of distrust between staff and/or management. Staff told us they knew how to challenge practices but some were not confident that they would be listened to. This left some members of staff unable to highlight their concerns which undermined the openness and honesty about care delivery. People using the service were reluctant to name members of staff who they said were not particularly caring or treated them poorly but could tell us the names of staff who treated them well. Staff had mixed views about teamwork. Comments included, "Sometimes it works sometimes it doesn't which is a shame really", "Fantastic, can't complain, some team leaders help some don't", "Not everyone might get along. I try to put work first before personal feelings" and "Staff should be celebrated more despite the various investigations that have taken place.

The provider had embarked on a staff morale building exercise to improve the relationships within the team. Some members of staff did not have confidence in the management team and their ability to resolve the negative staff dynamics at the service. However, they said the new manager who had started work at the service had engaged them and they were hopeful that she would address their concerns. A senior manager told us they were aware of allegations raised against the service including concerns around staff morale. Investigations had been carried out and the provider had plans in place to develop a cohesive staff team. Various efforts had been started to improve staff relations and the relationship with the management team. However, concerns raised by staff indicated that the issues were ongoing and the changes effected would need time to show a positive impact on staff relations and morale.

Communication between staff and management had improved and information about people was shared appropriately. Staff told us they had resumed having daily handovers as a team where they received updates about changes to people's health and the support each person required. Staff welcomed this development as it enabled them to communicate with each other in an organised manner and ensured accountability within the team. The manager said she had been attending the daily handover sessions to foster team building and appropriate sharing of information. Staff meetings were held to talk about people's needs, staff concerns and issues affecting the service.

People received care that underwent regular checks. Audits were carried out on the quality of the service on areas which included medicines management, care planning, communication logs and staff training and development. Improvements were made when needed. Incidents and accidents were monitored and reviewed. Records showed the manager discussed in supervisions incidents such as medicine management errors with the responsible staff to ensure they learnt from their mistake and that people received safe care. Senior members of staff completed some checks in between audits for example in relation to medicines management and how staff supported people to manage their finances. We reviewed some of the records which showed that checks were not sufficiently robust for example, when staff brought receipts and change to the person, the audits had not picked up that staff had not ensured the person signed as stated in the policy and procedures. We spoke with the manager and assistant manager who told us that they would improve on the system and highlight the need for staff of follow good practice.

People using the service and their relatives had opportunities to share their views about the service. People were happy with the updates and information they received through a newsletter. The provider carried out surveys to obtain their views. Staff informed the manager of feedback from their day to day interactions with people. The manager told us that head office analysed the results of surveys to see if there were any trends. We did not see the results of the latest survey. However, the manager said they had increased communication with people which enabled them to address issues as they arose. For example, there were plans to support people to engage in activities of their choosing.

Staff had access to policies and procedures to guide their practice. The provider reviewed and updated policies and procedures to ensure care delivery was in line with current legislation and best practice guidance. Staff told us they read and applied in their duties safe practices as highlighted in policies such as medicines management, safeguarding, whistleblowing and infection control.

People benefitted from the provider's joint working with other agencies. The local authority who commissioned the care of people using the service carried out monitoring visits. The latest audit report had raised issues around medicines management and care planning. The provider addressed the issues raised and had changed the format of care plans to ensure they were more person centred. The manager told us she would provide oversight on care planning and to ensure people received care in line with best practice guidance received from agencies.

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 12 HSCA RA Regulations 2014 Safe care and treatment 12 (1) (2) (a) (b) The provider had failed to ensure that care and support was provided in a safe way and had not done all that is reasonably practicable to mitigate any such risks.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing 18 (1) The provider had not deployed sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs.