Coghlan Lodges Limited

Coghlan Lodges

Inspection report

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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

We previously carried out an announced comprehensive inspection of this service on 22 August, 23 August, 24 August and 31 August 2017. Since that inspection, we received concerns in relation to several issues. This included information from local authorities, the police, people who used the service, members of the public and commissioners. As a result, we undertook a focused inspection to consider those concerns. This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Coghlan Lodges on our website at www.cqc.org.uk.

Our inspection site visits took place on 4 October, 5 October and 26 October 2018. The first day of our inspection was unannounced and the remaining two days were announced.

Coghlan Lodges is a 'supported living' service. The service provides 'personal care' to people living in a number of 'supported living' settings, so that they can live as independently as possible. Not everyone using Coghlan Lodges receives the regulated activity. We only inspect the service being received by people provided with 'personal care', which includes the prompting and supervision of tasks related to personal hygiene, eating and others. Where people do receive 'personal care' we also take into account any wider social care provided. At the time of our inspection, four people received 'personal care'.

The provider is required to have a registered manager as part of their conditions of registration. 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. At the time of our inspection, there was a manager registered with us.

People were not safe from abuse. Systems in place did not always ensure that vulnerable adults were protected from foreseeable risks. Recruitment processes were inadequate and did not ensure that only fit and proper staff were employed by the service. An effective mechanism for determining safe staffing deployment was not in place. Staffing was based on people's funded hours of care, and not their needs or dependency. Care risk assessments were completed, but were not always accurate and did not always contain sufficient information.

The governance of the service was unsatisfactory. Although a quality assurance tool was in place to log areas for improvement, issues were not always acted on promptly or sufficiently. When actions were marked off as complete, there were o further checks completed to ensure any changes put in place were suitable and sustained. The service did not always provide required information as required by the regulations. Record-keeping was inadequate, and the provider failed to comply with relevant legislative requirements for documentation.

The overall rating for this service is 'inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe and a rating of 'inadequate' remains for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration if they do not improve.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures.

There were a number of breaches of the regulations.

You can see what action we told the provider to take at the back of the full version of the 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.

People were not adequately protected against abuse and neglect.

The service had not ensured people's safety was sufficiently protected via robust recruitment processes.

People's incidents and accidents were not always reported. Actions were not always taken in a prompt manner to ensure people's safety.

Risk assessments were in place. However, risk assessments did not always contain adequate information about people's care needs.

A satisfactory system for safe staff deployment was not in place.

Is the service well-led?

Inadequate

The service was not well-led.

Governance systems to gauge the safety and quality of people's care were not effective.

Risks were not always effectively assessed, analysed and mitigated to ensure people's care was safe.

Record-keeping was not always sufficient.

The provider had failed to pay their annual registration fees for three years.

Improvements were required to ensure people's personal care and shared living arrangements met the real tenancy test.

Coghlan Lodges

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.

Our inspection site visit took place on 4 October, 5 October and 26 October 2018. The first day of our inspection was unannounced and the remaining two days were announced.

Our inspection was completed by an adult social care inspector, a specialist advisor (registered mental health nurse) and a registration inspector.

Our inspection was informed by evidence we already held about the service. We also checked for feedback we received from members of the public, local authorities and clinical commissioning groups (CCGs). We checked records held by Companies House and the Information Commissioner's Office (ICO).

As this was a responsive inspection, we did not require the service to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We asked the service for a list of health and social care professionals and commissioners prior to our inspection, and this was returned by the due date.

People who used the service were able to provide limited information to us, however we attempted to speak with them as part of our inspection. We spoke with the registered manager, the provider's business development executive and the service manager. We also spoke with the finance administrator and three care workers. We reviewed four people's care records, ten personnel files, medicines administration records and other records about the management of the service. We wrote to eight commissioners and received four replies. We spoke with two social workers.

After our inspection, the registered manager sent us further information. This evidence was included as part of our inspection. We also wrote to the provider after our inspection to seek further information and

evidence, which we used to inform our judgements.

Inadequate

Is the service safe?

Our findings

People were not always protected against abuse or neglect. Systems that were in place to safeguard people were not consistently used. We found evidence that one person was at high risk of financial abuse. A care worker explained the person's needs and preferences for spending their personal budget. They showed us records maintained for the person's finances. The recording sheet contained basic details such as the date, amount of money being provided and staff signatures. The sheet recorded single entries for each day, showing either the person received £30, or the person was involved in withdrawal of £300 from their bank account. There were no records of what the person used their money for.

Staff explained the person was in control of their own spending, and did not obtain any receipts. However, staff were aware of what the person spent their money on, as they always accompanied the person into the community. Therefore, staff had the opportunity to record this on the provider's document. The person's bank statements were received at their residential address and filed by staff. Staff and managers did not reconcile the bank statements against the finance recording sheet. When we checked one of the person's bank statements against the finance recording sheet, there were discrepancies. These included the dates on which cash withdrawals were made and the frequency of the withdrawals. The provider could not be assured that the person was not being subjected to financial abuse.

People were also at risk of physical harm because of neglect. The inspection team noted a care worker supporting a person in the community in a wheelchair. At one point, we observed the care worker on their mobile telephone and not paying due care and attention to the person's welfare. From where they were seated, the staff member did not have direct line of sight of the person and their movements. The person pushed themselves backwards in their wheelchair onto a street and into the line of traffic. Shortly after, the care worker started looking for the person and located them up the street. We reported this matter to the local authority via a safeguarding referral. We also informed the provider about the incident. The provider told us they had spoken with the staff member involved in the incident.

This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Providers are required to check all potential staff members are fit and proper to carry out their duties. The requirements for checking are set out in the regulation and associated schedule. We initially examined five personnel files. We were concerned about the content and the compliance of the checks, and expanded our observation to a further five personnel files. Each of the personnel files failed the mandatory requirements set out by the regulation and schedule in different ways. One staff member had a valid criminal history check from the Disclosure and Barring Service (DBS). The remaining nine staff did not have valid DBS checks. The nine DBS certificates on file were from prior employers and applications by Coghlan Lodges were not completed prior to the commencement of these staff. The provider could not be assured that staff were safe to work with vulnerable adults. Checks of staff conduct were insufficient. References were obtained from sources which were unrelated to the position the staff member had applied for, and in some cases, were fictitious. There were gaps in staff employment histories, reasons for leaving were not always completed on the job application form and relevant pre-existing qualifications were not copied. There was no evidence

that interviews were completed. Evidence consisted of the new staff member providing answers to a set of questions, which was then stored in the personnel file. We gave feedback to the provider of our findings who told us they would conduct DBS checks and had employed a new administrator.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people were assessed and recorded. Prior to commencement of a package of personal care, a senior manager completed an assessment of a person's needs in the community or healthcare facility. These were often completed rapidly if a person needed to be discharged from a hospital or similar setting. We viewed these assessments and found they were satisfactory. The provider then used a computerised care documentation system across multiple residential addresses and at the head office to record ongoing risks and care. This detailed information in a set format, and asked specific questions about the person's activities of daily living. For example, staff were required to enter the person's previous social and recreational history, medical health information, moving and handling needs, personal hygiene needs and eating and drinking requirements. Most of the risk assessments and associated care plans we viewed contained sufficient information and were reviewed regularly.

We pointed out to the senior management team one person we met as part of the inspection who appeared to require personal care. When we asked, the management team denied the person required personal care and only needed prompting. The risk assessments and care plans we viewed did not contain information which corroborated this. There was a lack of detail as to how much support the person needed. In other parts of the documents, there was evidence the person received personal care for some activities of daily living. Care workers we spoke with were clear about the person's needs and could explain them in detail. The staff's description of the person meant they in fact received personal care. We provided this feedback to the registered manager who provided an assurance they would review all client's risk assessments to ensure clarity of which people received personal care, as defined in the applicable regulation.

There was a system to document incidents, accidents and near misses. However, we noted this was not always completed or when it was, there was not sufficient detail. An example was a medicines incident on one day of the inspection. A person's medicines were given as prescribed, but from the wrong day of a monitored dose system ('blister pack'). We asked staff what they had done regarding the incident. The matter was not recorded on an incident report. We provided feedback to the registered manager who ensured it was correctly recorded. In another instance, a staff member's behaviour had placed another person at risk. There was a dereliction of their duty to ensure people's safety. The management team were alerted by the person's relative and police. The relative also notified the local authority and us. Delayed action was taken by the provider to deal with the issue and the staff member's performance management. We viewed evidence of this, and were later satisfied the matter was dealt with in an acceptable way.

Medicines were managed satisfactorily. Staff received training in medicines management. They were required to repeat the training at regular intervals. People's medicines were in 'blister packs' and accompanied by medicines administrations records (MARs) at their houses. In one house, we asked to see a person's MAR. It could not be located at the time. The staff member responsible could not recall where they had left the record. Historical records of the person's medicines administration were available, and we viewed these. The records showed no gaps in staff signatures. After some time, the missing MAR was later located, and presented to the inspection team to view; it was found in the person's bedroom. We advised the senior management team this was not an appropriate location for the record and that it should have been kept with the remainder of the MARs.

A suitable system for calculating safe staff deployment was not in place. We asked the senior management team to show how staff deployment was calculated. They provided a copy of a document named "Staffing matrix based on commissioned hours". The document showed the "number of (bed)rooms" at three addresses, the number of "patients" and the "patients support hours per week". The provider could not satisfactorily demonstrate how the staffing hours for people who received personal care were separated from the other residents at the addresses. The provider failed to calculate the dependence of the people who received personal care. The document showed total funded hours for all people who lived at the addresses ranged from 130 to 280 hours per week. When we examined the rotas, we saw staff deployment was consistently the same; two care workers on day shifts and two care workers on night shifts. Staffing for people who received personal care was linked to payments from commissioners, and not to people's needs or dependency.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted there were no entries in the rotas of staff undertaking personal development, training or any supernumerary functions. Staff that we spoke with told us there were occasions where other employees failed to attend their rostered shifts. The provider told us when this occurred, absent staff were replaced with agency staff. At other times, permanent staff members would complete additional shifts for staff who were absent. An on-call system was in place between the senior management team to manage any absences where short notice was provided by the staff member.

There were sufficient procedures in place for infection prevention and control. There was an appropriate policy, staff training and audits of infection prevention measures in place. Staff had access to personal protective equipment, such as disposable gloves and aprons. There was ready access to handwashing facilities at the addresses where staff provided personal care.

Inadequate

Is the service well-led?

Our findings

Stakeholders such as local authorities, the NHS and clinical commissioning groups we contacted provided mixed feedback about their working relationship with the service and the senior management team. In some instances, commissioners had rated the service as "red" or high risk, because of concerns about people's safety and the governance processes. These commissioners had requested action plans from the provider to address identified issues. We reviewed the three action plans that the provider had developed for the relevant commissioners. The content included specific incidents the provider was made aware of about people's safety by commissioners. Some of the content was copied from questions asked by commissioners, for example "what dependency assessment tool is used to decide the level of [staff] required…" The provider had almost entirely relied on information from commissioners to inform and formulate the action plans. There was less information pertaining to any risks the provider had identified themselves via internal monitoring processes.

Each topic in the action plan such as staffing, safeguarding, care plans, staff training and risk assessment stated a list of relevant actions. Each action was risk rated (either green, amber or red) to indicate the priority for acting. There was mention of who was responsible, and by when, but the names of individual staff members were not used, for example "area manager". It was not clear on the action plans which of the three area managers would take responsibility for ensuring the action was managed or completed. In the column titled "progress", there was listed evidence of actions taken to manage the risks, although sometimes the information was vague and suggested the action was ongoing. For example, in one action plan the progress for staffing deployment stated, "ensure that staff rotas are regular for continuity of care." This was marked off as complete, but the action plan provided no evidence of how this was resolved. All three action plans provided a single due by date for each item. None of the action plans listed revised dates, detailed any delays in implementation of strategies to reduce risks or dates for checks on sustainment of the actions. The action plans were not sufficient to ensure that all risks related to people's personal care were effectively assessed, analysed, and mitigated.

The provider had a clear organisational structure chart in place which detailed the roles of the senior management team, and who respectively reported to them. There were three area managers who were responsible for oversight of the provision of personal care to people (at various residential addresses). Regular meetings were held by the senior management team and the area managers. We looked at two sets of minutes from August 2018. These covered relevant areas of the service such as operational issues as well as management of staff, people's medicines safety, care documentation, and risk management. However, although the minutes covered a range of topics, they also contained large lists of actions related to each agenda item. The minutes did not always record the actions in an effective way. For example, an example was, "area managers to check MARS sheets…", but the required date for the action was not listed. The minutes did not record the priority for the actions. We saw within a five-day period between the two meetings held in August 2018, there were more than 100 actions listed for the management team. Some of the items identified were not actioned when we commenced our inspection. The service had not acted promptly on some of the highest risk issues, including protecting vulnerable people from abuse and management of medicines, as stated in key question "safe" of this report..

Record-keeping at Coghlan Lodges was not always satisfactory. A person attempted to obtain copies of their care records from the service. They told us they contacted the provider and were unable to obtain them. When we spoke with the senior management team regarding this, they told us all the care records were left at the person's address after their support package ended. The service failed to keep copies of the records at their office, as required by various legislation. The records could not be inspected by us nor could the person review what details were recorded about their care. We referred the person to the Information Commissioner's Office (ICO) so they could seek appropriate advice. We contacted the ICO about the matter. The ICO told us they investigated and found the provider had not maintained appropriate record-keeping systems.

The provider did not have a sufficient system in place to ensure full compliance with the real tenancy test ("the test"). The test is a quick method which must be used in supported living and tenancy-based supported housing, to determine if true tenancy terms are being met. The test asks 11 key questions to determine whether the tenancy is genuine, and gives guidance to ensure that the tenants have real tenancy rights. We have also published guidance about how providers must ensure they comply with the requirements of the "real tenancy test". We asked the provider for extensive information and documents to ensure the real tenancy test was in place for four people who used the service. We were provided with copies of letters to people and commissioners, bed allocation records, invoices and payments, license agreements (simplified tenancy arrangements), and landlord information.

Documents we examined showed the provider sometimes failed to comply with guidance and meet the provisions of parts of the test. For example, on Coghlan Lodges Limited letters to people about their care package, a section detailed "accommodation" and "rent/mortgage". There were no details as to why the provider was collecting rent. This meant the provider could be carrying out a regulated activity such as accommodation, which they are not registered for. At two people's addresses we visited, there was a staff office in the building. This did not indicate a place of private residence. People had license agreements in place, however the documents did not state the full legal entity of the landlord. The landlord was a limited company recorded on Companies House as in liquidation. The provider had not taken appropriate steps to ensure people's tenancies were properly protected from failures.

We examined invoices sent to commissioners of people's care. Invoices detailed costs relating to the cost of care support, rent, utilities and food for the period. This indicated the provider was collecting fees for the provision of personal care as well as accommodation within a consolidated invoice. When asked why these charges appeared on the same invoice, the business development executive stated that this a process set by the relevant local authority. The staff member stated the local authority requested that only one payment was made, rather than separate the payments for care services and rental charges.

The staff member went on to advise that the provider collected the rent payment and then paid the landlord. We asked the provider to produce the procedural agreement between the legal entities for this arrangement. The staff member stated the arrangement was informal. We asked the staff member if they could produce any evidence that would show the transfer of payments from one company to the other. They confirmed this information was not in place at the time of our inspection. The provider created a document following our inspection and sent us a copy.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Prior to our inspection, we checked whether the provider was on the register of fee payers maintained by the ICO. All services that handle confidential personal information are required to pay the fee and be on the

register. The provider was not on the register at the start of our inspection. We spoke with the registered manager about this. The registered manager checked and provided evidence to us that the fee was paid, as well as an updated certificate of registration. We checked the ICO register after our inspection and found the provider was listed.

There were times when the service was legally required to notify us, without delay, of certain events which occurred. The senior management team had reported various events to us in line with the regulation, but these notifications did not relate to people who received personal care. However, in one relevant example we reviewed, two people who received personal care were involved in an event where they were placed at risk. The service was informed about the matter on 18 August 2018, but failed to notify us until 9 September 2018. The provider had delayed reporting the event to us. This meant we could not effectively monitor the safety of the service and any impact on people's care.

This was a breach of Regulation 18 of the Care Quality Commission (2009) Regulations.

Providers that are registered organisations are required to advise us when there are proposed or actual changes to the structure of their limited company. On 30 August 2017, a new company director was appointed. The provider did not notify us of the new company director.

This was a breach of Regulation 15 of the Care Quality Commission (Registration) Regulations 2009.

The service was required to have a statement of purpose (SoP). A SoP documents key information such as the aims and objectives of the service, contact details, information about the registered manager and provider and the legal status of the service. We found the SoP for the service covered appropriate topics, but that some information was inaccurate or out of date. This included the location name, contacts for commissioners, local authorities and safeguarding teams. The location name was altered in February 2018, but the provider had not submitted an updated SoP to us within 28 days of the change. We pointed this out to the registered manager who stated they would update the content and send us a copy of the SoP. We did not receive a copy of the updated SoP within the timeframe required by the relevant regulation.

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 15 Registration Regulations 2009 Notifications – notices of change The registered person did not give notice in writing to the Commission, as soon as it was reasonably practicable to do so, of a change of director, secretary or other similar officer of the body.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person failed to notify the Commission, without delay of an incidents specified in the regulation which occurred whilst services were being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse. Systems and processes were not operated effectively to prevent abuse of service users.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person failed to effectively

assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). The registered person failed to effectively assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. The registered person failed to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not operated effectively to ensure that persons employed were of good character and had the qualifications, competence, skills and experience which were necessary for the work to be performed by them. The registered person had failed to ensure all information specific in Schedule 3 was available in relation in relation to each such person employed.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed in order to meet the requirements of this regulation.