Homewards Care Ltd

Homewards Limited - 51 Leonard Road

Inspection report

51 Leonard Road
Chingford
London
E4 8NE

Date of inspection visit:
29 August 2019

Date of publication:
24 October 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Homewards Limited - 51 Leonard Road is a residential care home registered to provided personal care support to up to three people with learning disabilities and/or autistic spectrum disorders. At the time of the inspection, three people were using the service.

The service had not been fully developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service did not always receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

People's experience of using this service and what we found
People were not supported by staff who were appropriately recruited. Staff rotas were not clear and accurate to confirm staff on duty. Risks to people were identified. However, the risk assessments did not always include actions staff were required to take to reduce the risks to people.

People were exposed to risk of harm due to health and safety issues with the garden. People were not safeguarded from the risk of infection. The provider lacked effective systems to learn lessons from accidents and incidents, and when things went wrong.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The service didn't always consistently apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence. The outcomes for people did not fully reflect the principles and values of Registering the Right Support as people did not receive safe personalised care.

The provider lacked effective systems to ensure the safety and quality of the service. During and following the inspection, although requested, we were not provided with evidence of the provider's quality audits and assurance systems.

Whilst staff knew signs and types of abuse, they did not know the whistleblowing procedure. We could not be confident people were appropriately safeguarded. We have made a recommendation in relation to the whistleblowing procedure. People received appropriate medicines management support.

Staff told us they felt supported and found the management approachable. Staff said they liked working with the provider. The provider worked with other healthcare professionals to enhance people's experiences.

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

Rating at last inspection
The last rating for this service was good (published 9 November 2018).

Why we inspected
We received concerns in relation to the management of medicines and staffing. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other Key Questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the Safe and Well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Homewards Limited – 51 Leonard Road on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, staffing, fit and proper persons employed and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Homewards Limited - 51 Leonard Road

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Homewards Limited - 51 Leonard Road is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this

information to plan our inspection.

During the inspection
We observed care and interactions between a staff member and one person who used the service. We spoke with four members of staff including the registered manager, the nominated individual and two care workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included three people's care records and medication records. We looked at seven staff files in relation to recruitment. A variety of records relating to the management of the service, including medicines audits were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We reviewed the documents the provider sent us following the inspection.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- The provider did not follow safe recruitment procedures to ensure people were supported by staff who were safe, of good character and skilled.
- We reviewed seven staff files and found gaps in all of them. Application forms were not fully completed, reasons for leaving were not always stated, there were gaps in staff employment history and these had not been explored. In addition, there were no interview notes to show a suitable recruitment process had been followed to determine whether staff had knowledge, experience and skills to work with people at risk.
- Not all staff references matched their employment history and there were several references from the provider's other businesses. We found two references for a staff member stating they were working in the UK for the duration of time they were not residing in the UK. These references were given by the provider's associated company in the UK.
- Two staff residence permits had expired, and there was no evidence confirming they had the right to work in the UK. Following the inspection, the provider sent us an updated residence permit for one staff member. However, the provider did not send us a renewed passport for another staff member to confirm they had the right to work in the UK.
- We asked the provider about the gaps in recruitment checks and they told us they would send us more information to address the issues. Following the inspection, the provider did not send us all the information to address the staff recruitment gaps.

The provider did not follow safe recruitment practices and put people at risk of harm. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We reviewed staff rotas and found staff names on the rotas did not match with staff working on the day of the inspection. We also found the staff rotas for the month of August 2019 did not provide a true picture of which staff worked that month. This meant we could not be assured of how many and which staff supported people during the month of August 2019.
- The provider told us they had not changed the staff rotas following the changes in staffing and would send us copies of most accurate staff rota. Following the inspection, the provider did not send us the updated staff rota.

The provider did not deploy staff appropriately which put people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us the staffing levels were enough and they worked well as a team.

Assessing risk, safety monitoring and management

● Risks to people's healthcare needs were identified and assessed. Risk assessments were for areas such as self-harm, absconding, behaviour, physical environment, personal care and medicines.

● However, risk assessments did not always include actions staff were required to take to mitigate risks. For example, the risk assessment for a person with diabetes did not state the associated risks and the actions staff were required to take if they noticed any signs of low or high blood sugar levels.

● The risk assessment for another person with behavioural needs did not state what diversion techniques staff were required to use when the person presented behaviour that challenged the service. There were no actions included for staff to take if these techniques did not work. This meant staff were not always provided with enough information on how to provide safe care.

● We looked at health and safety checks including fire equipment, gas, water and electric. We found water and electric checks were out of date. The provider told us these were in place but could not locate them on the day and would forward them to us following the inspection.

● Following the inspection the provider sent us portable appliance test certificate and legionella check certificate. However, they did not send water temperature checks. This meant we were not sure the provider carried out appropriate water checks to ensure it was safe for people to use.

● There were records of personal emergency evacuation plans for each person. However, these were not individualised to the needs and risks of the people who used the service.

● The London Fire Brigade (LFB) carried out an inspection in August 2019 where they found issues in relation to fire safety processes. The provider was sent a list of actions to be completed by end of October 2019 to meet the legal requirements.

● During our inspection, the provider showed us their response to the LFB where they challenged the LFB's findings. The provider told us they had not carried out any actions recommended by the LFB regarding fire safety as they were waiting for the LFB's reply.

● Following the inspection, the provider sent us an action plan detailing how they intend to complete the actions recommended by LFB if their challenges were not upheld. However, the action plan did not detail all the actions recommended by LFB.

● We found health and safety concerns in relation to the garden. The stairs to access the garden posed a safety risk for people as there were no handrails to support people when using them. The garden was overgrown and there were stinging nettles around the edge of the garden and by the trampoline. When stinging nettles come into contact with the skin, it can cause rash and a stinging sensation. This put people at risk of avoidable harm.

● There was a missing fence panel, which exposed the neighbour's fence panels that had spikes on them. There were two fence panels that were not fully secured. This put people at risk of harm. There was a washing machine in the garden stored in a broken plastic shed which meant the machine and wiring was exposed to weather conditions. This was a fire hazard.

● The trampoline in the garden had an unstable ladder and there were gaps between the hooks and the base of the trampoline. All this posed safety issues. The provider told us the trampoline was used by one person. However, there was no risk assessment in place for the safe use of trampoline.

Due to gaps in risk assessments and health and safety issues, people were put at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider sent us a trampoline risk assessment to ensure the people's safety when using the trampoline.

Preventing and controlling infection; Learning lessons when things go wrong

● We found the first-floor shower room did not have any hand wash facilities, the hand sanitiser by the front door was empty and there were no paper towels in the kitchen.

● We found the mops that were used by staff were not colour coded and some were not fit for purpose and needed replacing. This put people and staff at risk of cross infection.

● The provider did not have effective systems to ensure they were learning and sharing lessons when things went wrong. There were no records in place to show the provider gained learning from accidents or incidents, or shared lessons with the team to minimise them from happening again.

● This meant the provider did not identify trends and patterns for learning to take place to prevent reoccurrences of similar accidents and incidents.

The provider did not follow safe infection control practices, and lacked effective systems to ensure they learnt lessons when things went wrong. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff understood their responsibilities in safeguarding people from the risk of the spread of infection.

● The registered manager told us they would replenish the paper towels and hand sanitiser, and make sure the first-floor shower room had safe hand wash facilities. They further said and confirmed this in an email sent to us following the inspection, they had ordered new colour coded mops to prevent contamination.

● Records showed the provider took appropriate actions when things went wrong. For example, when there were any accidents and incidents, and safeguarding concerns.

● We spoke to the registered manager regarding learning from things that had gone wrong, and they told us moving forward they would analyse the incidents and accidents. They further said they would as a team learn lessons from them and record the learning outcomes for easy access and a better audit trail.

Systems and processes to safeguard people from the risk of abuse

● There were systems in place to ensure people were safeguarded from the risk of abuse.

● Staff were trained in safeguarding and knew their responsibilities in identifying and reporting any concerns or abuse. A staff member said, "It is about keeping [people who use the service] safe from abuse. I will tell the manager [of any concerns or abuse]."

● However, staff were not clear about whistleblowing procedures and who to call to blow the whistle. This meant if staff were concerned about the management's actions they did not know who to call. This put people and staff at risk of harm.

We recommend the provider consider current guidance on staff training in whistleblowing procedures.

Using medicines safely

● People received safe medicines management support. There were systems in place to order, store, administer, record and dispose of medicines appropriately.

● Medicines administration record charts were appropriately maintained. The provider carried out weekly checks and monthly audits to identify any issues and errors. There were records to confirm timely actions had been taken where issues were identified.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager did not demonstrate a good understanding of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014 and the duty of candour. This meant the service did not meet all the legal requirements.
- Staff knew their care responsibilities but were not aware of the regulatory requirements. For example, staff did not know their responsibilities in relation the Mental Capacity Act 2005.
- The provider told us they carried out regular monitoring checks and audits to ensure the safety and quality of the service. The provider told us they would email us their internal audits of the care plans, risk assessments, staff files and spot checks. However, during and following the inspection, the provider did not send us records of their internal audits.
- The provider's monitoring and auditing systems were not effective. The provider had not identified concerns regarding unsafe staff recruitment practices, insufficient risk assessments, health and safety issues, and poor infection control practices. The staff rotas were not accurate and there were no systems in place to gain learning from accidents and incidents.

There was a lack of effective audit systems to ensure the safety and quality of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- During the inspection we reviewed medicines audits. Medicines administration records and medicines management audits showed appropriate actions were taken when errors were identified.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- During the inspection we could not review the service's quality assurance systems to know how they engaged with people, their relatives and staff to continuously learn and improve the care delivery.
- The provider told us they would email us their quality assurance records to demonstrate how they sought feedback from people, their relatives and staff . This evidence was not forthcoming. This meant we could not evidence the provider had appropriate and effective systems in place to drive forward improvement.

We could not be assured whether the provider had systems in place to continuously learn and improve the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● One person we spoke with told us they were happy with the service.

● Staff told us the management was approachable and treated them without discrimination. A staff member said, "Yes, [registered manager] is approachable, he treats all [staff] and [people who used the service] fairly and nicely. Even if it is 2am you can call him."

● Staff told us they liked working with the provider. A staff member commented, "Yes, it is a good place to work. The best thing is that all staff would help each other if there are any problems. If there are any emergencies the manager is flexible in changing the rotas."

Working in partnership with others

● The provider worked with healthcare professionals such as GPs, staff from the community venues, social workers, behavioural psychologists and the commissioning team to enhance people's experiences.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons failed to effectively operate systems including to assess, monitor and improve the quality and safety of the services provided; assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others; maintain securely such other records as are necessary in relation to persons employed in the carrying on of the regulated activity and the management of the regulated activity, and seek and act on feedback from service users, their relatives and the staff. Regulation 17(1)(2)(a)(b)(d)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider failed to ensure persons employed for the purposes of carrying on a regulated activity must be of good character, to establish and operate recruitment procedures effectively, and the information must be available in relation to each person employed as specified in Schedule 3. Regulation 19(1)(a)(2)(a)(3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person failed to ensure staff

were appropriately deployed. This put people at risk of harm.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider failed to ensure people received care in a consistently safe way. This included failure to assessing the risks to the health and safety of service users of receiving the care or treatment, doing all that is reasonably practicable to mitigate any such risks, ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way, and assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. Regulation 12(1)(2)(a)(b)(d)(h)

The enforcement action we took:

We served the provider with the warning notice.