Housing & Care 21

Housing & Care 21 - Belsize Court

Inspection report

Belsize Court
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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?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 12 May 2016 at which we rated the service 'Requires improvement' and found breaches of two regulations. These related to providing safe care and treatment, particularly in identifying and managing risks to people's safety and good governance in relation to systems to review service quality. We then undertook a focused inspection on 25 October 2016 and found they were then meeting legal requirements.

Before this inspection we received concerning information about medicines management practices. We carried out this inspection to look at these concerns as well as all other aspects of service provision. This inspection took place on 21 April 2017 and was announced.

Housing & Care 21 – Belsize Court is an extra care scheme. Belsize Court has a total of 63 flats for people aged 55 years and older. Thirty people using the service at the time of the inspection were receiving support from staff with their personal care, the majority of whom were living with advanced dementia and some had other complex mental and physical health needs. Both the housing service and the care service were provided by Housing &Care 21.

At our previous inspections the service did not have a registered manager. At this inspection the service still did not have a registered manager. The manager who was newly in post at our last inspection had not yet completed the process to register with us. 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.

Staff did not manage people's medicines safely. Senior staff copied the prescribers' instructions onto people's medicines administrations records and we found errors in transcribing which meant people did not always receive their medicines as prescribed. Poor stock control by the provider meant people sometimes ran out of medicines and prompt action was not taken to obtain the required medicines.

Appropriate risk assessments and management plans were not always in place in relation to some risks to people, including risks relating to malnutrition, alcoholism, skin breakdown, behaviours that challenged and risks relating to catheter care.

Robust systems were not in place to review the quality of service provision and medicines audits failed to identify any of the issues we found during our inspection. In addition auditing systems had not identified the other issues we found during our inspection. Some information in care plans was inaccurate which meant people were at risk of receiving inappropriate care.

The management team did not appreciate their responsibilities to ensure applications were made to the Court of Protection to deprive people of their liberty lawfully as part of keeping them safe. Staff had a limited understanding of their responsibilities under the Mental Capacity Act 2005 (MCA) and what constitutes a

deprivation of liberty.

People were positive about staff and told us they were kind. However we observed staff did not always respond appropriately to people living with dementia who were disorientated to time and place and agitated. In addition staff did not always ensure people's privacy and dignity was maintained when providing personal care.

A staff training programme was in place although suitable training in relation to medicines management and catheter care in order to help staff understand people's needs was lacking. Staff were supported through supervision and new staff followed a suitable induction. Further training was provided to staff such as diplomas in health and social care and leadership and management qualifications for the management team.

Staff were recruited through robust procedures to check their suitability. There were enough staff deployed to support people. Staff understood how to respond if they suspected people were being abused to keep them safe and the manager reported safeguarding concerns to the local authority appropriately.

The provider recently set up systems to monitor equipment such as hoists to make sure these were safe to use.

People received support in relation to food and drink and to access healthcare services such as GPs and dentists.

Staff knew people including their backgrounds and preferences and this information was recorded in care plans. Staff involved people in making choices about their care. The provider gathered information from the local authority and people to assess their needs before they began using the service.

Staff supported people to access activities they were interested in. There was a suitable complaints process in place. The provider had various ways of gathering feedback on the service from people and staff.

We found breaches of the regulations relating to safe care and treatment, good governance and deprivation of liberty. We issued warning notices in relation to the breaches concerning safe care and treatment and good governance. You can see what action we have asked the provider to take to address the breach relating to deprivation of liberty at the back 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

The service was not always safe. Medicines were not always managed safely as people did not always receive their medicines in line with their prescriptions. They also sometimes ran out of medicines due to poor stock control. Risks to people were not always assessed properly with suitable risk management plans in place to ensure these were minimised whenever possible.

People were safeguarded from abuse by staff. Recruitment processes were robust in checking staff were suitable to work with people using the service. There were enough staff deployed to meet people's needs. The provider was putting in place processes to ensure equipment was managed safely.

Is the service effective?

Requires Improvement

The service was not always effective. The provider had not made arrangement to ensure people were only deprived of their liberty as part of keeping them safe in a lawful way. Staff did not understand their responsibilities in relation to the Mental Capacity Act (2005) well.

Staff generally were well supported with a programme of induction, training, supervision and appraisal. However, there were some courses which the provider had not suitably provided them to help meet people's needs. Staff supported people appropriately with their needs in relation to eating and drinking and health.

Is the service caring?

Requires Improvement

The service was not always caring. Staff did not always respond appropriately when people showed signs of distress. Staff did not always ensure people's privacy when providing personal care to people.

Staff knew the people they were caring for and supporting and how they preferred to receive their care. Staff supported people to make choices. Relatives were able to visit without restriction which helped maintain their support networks.

Is the service responsive?

Good

The service was responsive. Staff identified the support people required and how they wanted this support delivered.

An activity programme was in place based on people's interests. A suitable complaints process was in place.

Is the service well-led?

Requires Improvement

The service was not always well led. The audits in place for the provider to assess, monitor and improve the service were insufficient as they had not identified the issues we found.

There was no registered manager in post as the manager was still waiting for some information before submitting their registration application.

The manager encouraged open communication with people and staff.

Housing & Care 21 - Belsize 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, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 26 April 2017 and was announced to make sure a senior person would be available to meet with us. It was carried out by one inspector, a pharmacist 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.

Before our inspection we reviewed information we held about the service. This included statutory notifications received from the provider since the last inspection and the Provider Information Return (PIR). The PIR is a form we asked the provider to complete prior to our visit which gives us some key information about the service, including what the service does well, what the service could do better and improvements they plan to make.

During our inspection we spoke with four people as the manager told us only four people would be able to converse with us, with the other people not being able to because they were living with advanced dementia. We spent time observing how care and support was provided to them in communal areas. We also spoke to the manager, the regional extra care manager, the team leader, the activities officer and three care workers. To assess how the service manages medicines we looked at six people's medicines administration records (MAR) records and other records relating to medicines management. We also looked at four people's care plans and three staff files as well as other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Prior to the inspection we received information of concern about the management of medicines. A relative raised concerns about the way staff managed their family members' medicines and there had been a safeguarding investigation concerning the maladministration of medicines which had been upheld.

During our inspection we found people's medicines were not managed safely by the provider. Staff wrote instructions for administering medicines on the administration records (MAR) by hand, copying information from labels on medicines delivered to people. There was no process for checking the information recorded was accurate, such as by a second member of staff. Handwriting instructions on MAR in this way, instead of allowing the dispensing pharmacy to carry out this task, means there is risk of recording errors. This is contrary to guidance in 'Managing medicines for adults receiving social care in the community' (National Institute of Clinical and Healthcare Excellence, 2017). In addition, staff did not always record the dosage for administration and the course length for antibiotics so staff were clear how and for how long they should administer some medicines. During our inspection we found many recording errors on people's MAR which resulted in people not receiving medicines as prescribed. When we informed the manager of our concerns they told us they agreed with our findings and would urgently review their procedures.

We also identified numerous instances where either people ran out of medicines or the medicines went missing. There had been no investigations into why the medicines had run out and no prompt action taken to obtain the medicine when it was first found to be missing. When we queried this with staff it transpired there were no clear processes to ensure people did not run out of medicines or for ensuring medicines were promptly obtained if they did go missing. In addition, when people ran out of medicines this was not always raised by staff appropriately as a concern which meant medicines were not promptly reordered.

We identified an instance where a person's medicine to be administered weekly was administered by staff two days late. Staff did recognise the risks to the person in administering this medicine late, did not obtain medical advice and did not record what happened on an incident form. Where staff administered a variable dose of medicines, such as one or two tablets of paracetamol, depending on people's need, staff did not clearly record the dose they had given. This meant records of administration could not be relied upon to understand the medicines people had taken.

Staff did not make records of medicines returned to the pharmacy after August 2016 when the central record was stopped. This was against the provider's own policy for dealing with medicines returns.

At our inspection in May 2016 we found staff had not consistently identified, managed and mitigated the risks to people's safety. Appropriate assessments and management plans were not in place for risks such as falling and in relation to moving and handling. At our inspection in October 2016 we found the provider had reviewed and updated assessments to identify risks to people's safety and put risk management plans in place for staff to follow in supporting people.

However, at this inspection we again found staff were not always identifying and managing risks to people's

safety. We identified the risk assessment process did not always identify risks to individuals for which they required support to stay safe, and management plans were not in place to guide staff on how to support people to reduce these risks. These included risks relating to the management of medicines, malnutrition, alcoholism, skin breakdown due to incontinence, aggressive behaviours and risks relating to catheter care.

These issues meant the provider was in breach of Regulation 12 of the HSCA 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe. One person told us, "I feel safe everywhere." At our last comprehensive inspection we found staff were knowledgeable in recognising the signs that a person may have been subject to harm. They were aware of their responsibilities to report and record any safeguarding concerns, and knew how to escalate their concerns to the local authority safeguarding team to help protect people's safety. At this inspection our discussions with staff showed this was still the case. In addition the manager had taken the necessary action in reporting safeguarding concerns to the local authority for investigation.

At our last comprehensive inspection we also found staff were recruited following robust recruitment practices with appropriate checks of references from previous employers, checking people's identity and eligibility to work in the UK, and completing criminal record checks. At this inspection we found recruitment practices remained robust in checking staff suitability to work with people using the service. In addition managers attended a course on recruitment best practice which covered the documents required as part of recruitment and how to spot falsified documents.

A person told us, "[Staff are] always on time, they are all understanding and take their time." Another person told us staff were 'roughly' on time. We found there were enough staff deployed to work with people and people told us staff provided care in an unhurried manner.

In the most recent audit by the organisation's quality team it was identified that there was no clear process for ensuring equipment such as hoists was regularly checked and maintained. We identified staff had since logged details relating to equipment on the services' new electronic quality assurance system. The management team told us they would contact the relevant contractors when necessary to ensure equipment was safely maintained and they would review processes for risk assessments and checks relating to bed rails.

Requires Improvement

Is the service effective?

Our findings

We identified several people who may have been subjected to restrictions which could have amounted to them having their liberty deprived unlawfully. We observed a person who appeared disorientated to time and place telling staff they wanted to leave the service and staff used distraction techniques to prevent them from doing so. Staff told us this situation happened a lot with people who lacked capacity to consent to leaving the service, and several people had door sensors to alert staff to when they may be trying to leave. Staff told us they 'stopped [people] and reassured them' as part of keeping them safe. In addition there were several people with bed rails which could also constitute restrictions amounting to a deprivation of liberty. When we queried this with the management team it transpired they did not fully understand their responsibilities to ensure people using their service were not deprived of their liberty unlawfully. The provider had not assessed whether any people were likely to require authorisations to deprive them of their liberty and so had not initiated any applications. The manager told us they would immediately look into this and take the necessary action to ensure they were depriving people of their liberty in line with the law.

This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Our discussions with staff showed their knowledge and understanding of the Mental Capacity Act 2005 (MCA) and what constitutes a deprivation of liberty were limited. However, staff understood the importance of only providing care to people with their consent. The manager told us staff received some training in MCA but they would look at providing additional training and support to staff in these areas.

A staff training programme was in place with included training in topics relevant to people's needs, such as moving and handling and safeguarding adults at risk. Staff told us the training was of good quality. However, we identified staff had not received any training to ensure a person received catheter care safely. This increased the risks to this person of injury and infection as staff may not have been providing catheter care to them safely. The manager told us they would review the training programme in relation to this need. In addition, staff received medicines training and assessment delivered by two senior staff members. However, our findings in relation to medicines and our discussions with these two staff showed fundamental knowledge gaps which meant they could not effectively train and assess other staff in relation to safe medicines management.

Staff were supported to access further training to enhance their knowledge in key areas, such as Diploma's in Health and Social Care. The manager was enrolled in the Diploma in leadership and management Level 5, a qualification specific to managing care services and the team leader planned to enrol on this. In addition the manager and team leader were enrolled on the organisation's nine month 'leading to excellence' programme for all managers. This covered management topics such as recruitment and selection, sickness

and absence management, handling disciplinary and grievance and performance management amongst other areas. New staff were supported to complete an induction programme in line with the Care Certificate. The Care Certificate is a national induction programme designed to give all new care workers the same knowledge, skills and behaviours when they begin their roles. It covers the basic range of topics all care workers should know as part of their role. The induction also involved shadowing other members of staff to learn the best ways to care for people.

Staff told us they felt well support by management. However, staff did not receive formal supervision in a format where they could raise issues and discuss training needs. The manager told us they had an 'open door policy' and staff could raise issues with them at any time. In addition records showed staff frequently received spot checks and direct observations of their performance by management. The manager said they would review their supervision process in line with our comments. Staff received annual appraisal where their performance was reviewed and goals set for the coming year.

People made positive comments to us about the food they were provided with by staff. Staff provided people with the support they needed to eat and drink, which included preparing meals and cutting food up for people. The manager referred a person at risk of malnutrition to a dietitian and staff followed their advice in making their meals more nutritious. People were also able to purchase meals in the restaurant on-site.

A person told us, "[Staff make] the appointment for you". Staff supported people appropriately in relation to their healthcare needs including arranging home visits from their GPs, district nurses, dentists, opticians and chiropodists. The manager liaised with people's relatives and social workers where necessary to ensure they were referred to additional healthcare services, such as the dietitian.

Requires Improvement

Is the service caring?

Our findings

People were positive about staff. One person told us, "Staff are excellent absolutely excellent" and another person said, "The staff are good." When we asked people if staff were kind and caring they said they were.

Our discussions with staff showed they meant well and we observed positive interactions between staff and people who used the service. However, during the afternoon sing-a-long activity we observed staff did not always respond appropriately to people living with dementia who were disorientated to time and place and agitated. When people asked questions such as 'Where am I?', 'What are we going to do?' and 'What time is it?' staff did not respond to their questions.

People told us staff treated them with dignity and respect. However, during our inspection we found on one occasion staff did not lock a toilet door while providing personal care to a person to ensure their dignity.

Our discussions with staff showed they understood the individual needs of the people they cared for, as well as their backgrounds, their preferences and the people who were important to them and this information was recorded in people's care plans for staff to refer to.

Staff involved people in their care and supported them to make choices about how they received care and how it was delivered. Our discussions with staff showed they understood the importance of providing choices to people in the way they provided care and support to them.

Relatives were able to visit without restriction which helped people maintain their support networks.

Good

Is the service responsive?

Our findings

The management team assessed people before they came to live at the service, reviewing information from the local authority about people such as their backgrounds and mental and physical health needs. The care package from the local authority contained details such as the days and times staff should visit people and the care staff should provide during these visits. The management team also met with people to find out more about them, as well as details of how they wanted their care to be provided. The management team then created care plans for people based on this information. The care plans were detailed and described the action staff needed to take to meet people's needs.

The service continued to have a model of care which enabled a flexible and responsive service to be delivered. A 'flex' service was delivered to meet people's scheduled and allocated visits, with the flexibility of adapting to meet people's changing needs. A 'core' service was available at all times to respond to people's unexpected needs. This included supporting people who required it whilst using communal areas, and in response to pendant alarms being activated. We identified occasionally staff were required to provide personal care, under the 'core' service, to a person who usually received this type of care from a personal assistant not employed by the provider. The provider did not have a care plan in place to guide staff on the best ways to support this person with their personal care needs. We asked the manager to review how often staff were supporting this person with personal care so they could put a care plan in place if staff were supporting them to meet any identified needs.

A person told us, "There are church visitors, I go to that". An activities officer was in post who led a range of activities each week in the communal lounge. These included sing-along's, sometimes with professional singers visiting, bingo, arts and crafts and games. The activities officer told us they often visited people in their own flats for 'chats'. The activities officer involved people in choosing the activities on offer by asking their preferences. People were also asked for their feedback on the service through satisfaction surveys which the provider analysed to identify any patterns of positive feedback and to address any concerns raised.

The provider continued to have a suitable complaints process where complaints were logged appropriately, investigated and responded to. People told us they would 'speak to staff if they wanted to complain and all people were provided with information about the complaints process when they started using the service.

Requires Improvement

Is the service well-led?

Our findings

At our inspection in May 2016 we rated the service 'Requires improvement' for the key question 'Is the service well led?'. This was because a registered manager was not in post and there lacked consistent management oversight at the service with insufficient systems to review aspects of service delivery. At our inspection in October 2016 we found a new manager was in post who had started their application to register with the CQC and the provider had improved systems to review the service.

At this inspection we found the manager was still not yet registered with the CQC. This was because they were still awaiting some information before submitting their application to be registered. In addition although there was a range of audits in place to assess and monitor the safety and quality of the service provision, these had not identified the concerns and issues we found such as those relating to medicines management, risk assessments and deprivation of liberty. For example, there was a weekly medicines audit which had not identified any of the medicines issues we identified, with staff recording there were no concerns each week.

In another case staff administered medicines to a person around 1am each night even though their recorded care package did not include a scheduled visit at this time, with their last scheduled visit being 10pm. Staff told us this call had been agreed and was required to avoid the effects of medicines interactions, although they were unable to provide any evidence for this. This inconsistency between the care delivered and the recorded care plan indicated the person's care plan might have been inaccurate and the issue had not been identified by the provider's own checks.

The issues identified above meant the provider was in breach of Regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014.

The regional extra care manager had recently started work with the provider. They told us part of their role would be to visit the service regularly, auditing various areas to check and improve quality standards.

The manager showed us the provider's new electronic system for reviewing key performance data. As part of this the manager logged key data to enable monitoring of staff training and supervision, staff recruitment and staff recruitment files, accidents and incidents, complaints, safeguarding investigations and care plans and risk assessment reviews. The manager explained this system would alert them when key documents such as risk assessments and care plans required reviewing, or when staff supervision had not taken place as planned so they could take the necessary action to update them. The senior management team had access to this data and the extra care manager told us they would use this data as part of monitoring the service.

The provider's operational auditing team continued to audit the service in line with CQC requirements. Although this had not identified the concerns we found at the inspection, it had identified other concerns and tracked improvements over time. This was because the manager was required to respond to any concerns identified by the audit tool within agreed timescales. The latest report from October 2016 showed

the manager had made many improvements to the service in line with concerns identified at a previous inspection. The extra care manager told us the auditors would use our findings as part of their own audits of the service and would track the necessary improvements were made.

People told us there was a 'tenants meetings about once a year' at which they were asked for feedback on the service. The management team monitored the quality of staff support to people during 'spot checks' and 'observations' which was a useful way of understanding the experience of the many people who were unable to provide verbal feedback on the service due their complex needs.

The provider had open and inclusive ways of communicating with and supporting staff. Staff told us they felt well supported by the manager in their role and that they were approachable and responsive to any issues they raised. Staff meetings were held every three months and staff told us these were a useful opportunity to provide feedback on the service and be informed of any service updates. In addition other meetings were held for managers at different levels of the organisation to share learning and best practice. The provider held annual events to update all staff on corporate developments, inviting staff to 'shape the future of the organisation', with specific sessions focusing on extra care. Staff were invited to nominate colleagues who they felt deserved recognition at these events.

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 11 HSCA RA Regulations 2014 Need for consent The registered person did not have suitable arrangements to ensure the service acted in accordance with the Mental Capacity Act 2005 when people lacked capacity to consent. Regulation 11(1)(2)(3)

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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care was not provided to people in a safe way through the proper and safe management of medicines, ensuring sufficient supplies of medicines and assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. Regulation 12 (1)(2)(a)(b)(f)(g).

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established and operating effectively to assess, monitor and improve the quality and safety of the services provided, and to maintain securely an accurate, complete and contemporaneous record in respect of each person, including decisions taken in relation to the care provided. The provider also did not always maintain securely records relating to the management of the service. Regulation 17(1)(2)(a)(b).

The enforcement action we took:

We issued a warning notice.