Unified Care Limited

30 Coleraine Rd

Inspection report

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Date of inspection visit: July 2014
Date of publication: 18/03/2015

Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

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 pilot a new inspection process being introduced by the Care Quality Commission (CQC) which looks at the overall quality of the service.

This inspection was unannounced. At our last inspection in December 2013 we found the service met all the regulations we looked at.

30 Coleraine Road is a care home providing care and support to up to four adults with learning disabilities, autism and mental health. Each person has their own room and shares a communal lounge, kitchen, bathroom and dining area. At the time of our inspection there were four people using the service.

At the time of our inspection the service did not have a registered manager in place. A registered manager is a person who has registered with CQC to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. The manager had been newly appointed in June 2014 and had yet to submit an application to CQC to become the registered manager.

Summary of findings

We spoke with two people living at the home. One person told us, “I feel very safe.” Another person said, “its ok here.” One relative felt their relative was not safe living at the service.

During this inspection we found a number of breaches relating to cleanliness and infection control, management of medicines, staffing numbers and quality monitoring of the service.

People were at risk of acquiring a healthcare related infection because the provider had not taken appropriate steps to ensure the home was clean. For example, there were no hand washing gel or paper towels in communal bathrooms for people to wash and dry their hands. The communal stairway was dirty and unkempt. We found that the home was inadequately maintained, for example one first floor bathroom did not have a window restrictor. This put people at risk of falling out of the window.

People’s medicines were not stored safely and appropriately disposed of appropriately. We saw that medicines were stored in an area which had poor lighting. This made it difficult for staff to read people’s prescribed medicine. The medicine cupboard was not secured to the wall and medicine no longer required were kept on the floor inside and outside of the cupboard and had not been disposed of.

Staffing numbers were not sufficient to meet people’s needs. Staff told us that there was not enough staff to take people out into the community. On the day of our inspection we saw that people who required one to one care at all times were not always provided with this.

Systems for monitoring the quality of the service were not effective, because audits conducted by the provider had failed to identify the issues found on the day of our inspection.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 put at risk because the provider did not have systems in place to ensure the building was adequately maintained, medicines were safely stored and there was sufficient staff available to meet people's needs.

People were not protected against the risk of infection as the service did not have appropriate systems to ensure that the building was kept clean and hand gel and paper towels were not in the communal bathrooms for people to wash and dry their hands.

The service completed risk assessments, however not all staff understood people's risks and how to manage these.

Although staff knew what to do if they had concerns a person was being abused, staff were not aware of Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA) and the impact of this on the people they cared for.

Is the service effective?

Requires Improvement

The service was not always effective.

We saw the service provided training for staff, however this was not always effective as staff did not feel they had the skills to support people whose behaviours challenged the service.

People were given a choice of food and drink.

People had access to healthcare professionals as needed and individuals had hospital passports which would enable professionals who did not know them to better understand their individual needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Although we observed staff treated people with dignity and respect, we saw that people were not always given their privacy when they used the telephone.

Staff were not aware of people's personal histories prior to living at the service.

People at the home had access to an independent advocate if this was needed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although people took part in activities, staff were not always responsive to people's individual needs.

Summary of findings

Each person had an individual activity plan in place. However, staff shortage sometimes prevented people from taking part in their chosen activities.

Is the service well-led?

Requires Improvement

The service was not well-led.

People were put at risk of receiving a poor quality service because monitoring systems used were not effective in identifying and resolving issues raised on the day of our inspection.

The provider had completed a consultation exercise and sought feedback from people and their relatives.

There were systems in place for incidents and accidents and learning from these had occurred.

30 Coleraine Rd

Detailed findings

Background to this inspection

We inspected 30 Coleraine Road on 21 July 2014.

The inspection team consisted of two inspectors and a specialist professional advisor who was a nurse with experience of medicines and of working with people with learning disabilities.

Before the inspection we reviewed information we held about the service and the provider. Following our visit the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with two of the four people living at the home, one relative, three care workers and the manager. Prior to and following our visit we spoke with local authority commissioners.

We reviewed care records for three people living at the home, personnel files for two staff and audits carried out by the service.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Inadequate

Is the service safe?

Our findings

People and their relatives did not always feel safe living at the home. We spoke with two people living at the home. Whilst one person told us, "I feel very safe," another person responded with, "no," to the question of whether they felt safe. One relative told us that their relative was not safe and spent most of their day at a neighbouring home. The relative also told us that they were frightened to visit their relative at the home and had arranged to meet them at the neighbouring home. When we spoke with the manager she was aware and had put plans in place to support the person and the relative.

One person at the home had recently been seen by the local authority who had identified risks to this person and others who lived at the home. The service did not always protect people from bullying and harassment. We saw one person who had been subjected to bullying and harassment by another person living at the home who said they did not feel safe at the home.

We spoke with a relative who told us that they did not feel their relative's needs had been met by the service. Following a number of incidents, involving their relative being attacked by another resident, the person felt unable to remain in the home and often visited the neighbouring home. This relative who had also been attacked by this person did not feel comfortable visiting the home. The local authority commission team have been working closely with the provider to support this person and the home. Safeguarding alert was raised by the local authority and a meeting held to discuss actions to be taken by the provider.

Staff we spoke with felt unsafe and did not feel they had the knowledge and understanding to manage behaviours that challenged the service. We observed that staff had to use their personal mobile phones in an emergency as the home did not have a phone for staff or people to use.

We reviewed two risk assessments and saw that these did not always identify people's individual risks or record when people's risk had changed. There were no individual risk assessments in place for keeping the main front door locked. We reviewed one person who had a risk management plan in place to assist staff to manage behaviours that challenged the service. However, staff we spoke with did not fully understand people's risks and how to manage these.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff we spoke with knew what to do if they suspect that someone was suffering abuse, including reporting any concerns in the first instance to the manager, local authority safeguarding team or the Police. However, staff we spoke with did not have an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and the impact of this on the people they cared for. One person was subject to a DoLS to keep the front door locked to prevent them from causing harm to themselves or others in the community. The manager told us that three of the four people living at the home had keys to the main door to allow them to come and go as they please. However, we were unable to confirm this with people living at the home.

People and staff were at risk of acquiring a health care associated infection. We saw the home did not have a cleaning schedule, therefore levels of cleanliness was not adequate. We observed that the communal stairs were dirty and dusty and on one floor there was a foul smell. In the communal bathroom and toilet there was no hand washing gel and paper towels for people to wash and dry their hands. In the toilet we saw that the fan was dusty and greasy with grime. In one person's bedroom we found a stained head board.

We saw that the people living at the home had completed a recent questionnaire which was contrary to our findings at the inspection. This showed that most people felt the house was as clean as they would like it to be, although one person commented that staff should, "clean under the bed." Most stated that the food was, "good."

In the kitchen we found dirty skirting boards, inside cupboards were stained, the cooker was old and dirty and the extractor fan was greasy. In the fridge we found food opened and no date recorded of when this had been opened. For example, two packets of ham left opened,

Inadequate

Is the service safe?

unsealed and not dated. The freezer also contained several opened foods with no date of when these had been opened and freezer drawers were dirty. This put people at risk of food poisoning.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

We reviewed the way medicines were stored and managed by the service. One person told us, "Staff look after my meds." They told us that they knew what their medicine was for. Staff we spoke with did not know what people's medicines were for and the possible side effects of these. We observed a staff member dispensing medicines from the medicines store room which had no light, and medicines had to be removed from this room in to the hallway where there was light.

Medicines were not stored or returned to the pharmacy safely. We saw that the medicine cupboard was not secured to the wall and the cupboard was dirty and dusty. Staff told us that this room was not cleaned. Therefore medicines were not stored safely and did not meet the legal requirements for storing medicines. We reviewed medicines administration records (MAR) for four people. Staff had recorded when medicine had been given and we saw that there were no gaps in recording. We reviewed how the service returned their medicines. We saw that returns were stored in several different places within the room, which included on the floor. We could see no returns book and staff we spoke with were unsure how medicines were returned to the pharmacy.

There was a first aid box in which several items were out of date and left open, such as sterile bandages with no date and plasters with an expiry date of August 2008.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

On the day of our inspection we saw that two people who required one-to-one care were not always provided with this. We observed that staffing numbers were not sufficient to meet people's needs. Staff told us that there was not enough staff to take people out into the community. On arrival at the home we saw that there were two staff on duty each providing one to one care. We reviewed the staff rota on the day of our inspection and noted that this showed that there should be three staff on duty for the morning shift and two for the afternoon shift. However, we saw that there were only two staff on duty and two of the four people living at the home required 24 hour one-to-one support, therefore there was not enough staff on duty to meet the needs of the remaining people living at the home.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

We reviewed personnel files for two staff and saw criminal record checks and references were obtained before commencing employment, as well as undergoing an interview process. The manager also checked that staff were legally permitted to work in the UK. Therefore the provider had carried out the necessary employment checks prior to staff commencing work.

Requires Improvement

Is the service effective?

Our findings

People told us that some staff were good and others not so good. One person commented, "It's ok, it's good." Another person told us that staff spent time on their mobile phones and did not always listen to them.

Staff told us that they had received recent supervision. The manager told us that with the exception of one all staff had last received supervision in June 2014. We saw that the one remaining staff member had been booked in the diary for July 2014. However, the manager told us that staff appraisals had not taken place for some time. Most staff told us that they felt supported by the new manager. However, some staff said they did not always feel supported by senior management.

Staff records showed that staff had received an induction before starting work. This included on the job training with staff shadowing more experienced staff. The manager showed us a staff training matrix which listed training completed by staff and covered training in areas such as safe handling of medicines, safeguarding adults, equality and diversity, infection control and challenging behaviour. However, training had not always been effective. For example, staff told us that they did not always feel equipped to support people who challenged the service and they had not all received any specialist training in working with people with learning disabilities.

There was a menu displayed on the kitchen wall. People told us most meals were prepared by staff. People told us that they were given a choice of foods and they sometimes made their own food. On the day we inspected we saw that there was very little food available at the home. Staff told us that there was a limited budget for food. One person living at the home told us that they did not often have meat or fresh fruit as there was not enough money. However, we saw that staff went food shopping on the day we visited, which was also the day the service did their weekly shopping. We spoke to the manager about this who told us that the provider was reviewing spending at the home.

People had access to healthcare professionals to assist staff to meet their needs. We saw records of appointments with the GP, dentist and optician. Each person had a medical appointment sheet with details of when they were last seen by a healthcare professional. We saw that each person had a health action plan (HAP). This detailed areas such as people's medical conditions and things people needed to do to stay healthy. Staff told us that they were responsible for ensuring that people attended their appointments.

We saw that each person had a hospital passport detailing their individual needs and contacts.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us that staff were ok. One person told us, “Staff are all ok. Staff sometimes listen.” Another person told us, “I’m very happy.” They told us that staff knocked on their door before entering. This was confirmed by a recent questionnaire completed by people living at the home.

We observed that staff treated people with dignity and respect. During the inspection we observed staff knocking on people’s doors before entering and staff communicating with people in a very kind and caring manner. However, we noted that there was very little interaction between staff and people at the home. Although staff were able to tell us about people’s individual needs and how the service accommodated these, they did not know about people’s personal histories. The manager told us that the service was in the process of reviewing the format of the care plans to incorporate people’s past histories, this would enable staff to have a better understanding of how to care for the people they support. We saw that this work had started and saw that this had involved relatives. The manager told us that these changes would be fully implemented by the end of August 2014.

We noted that the service did not have a communal phone, therefore people were unable to contact family or the emergency services should this need arise. Staff told us that they used their personal mobiles to make calls and people were encouraged to use staff personal mobiles phones to contact their relatives, therefore people did not always have their privacy respected. The manager told us that the communal phone had not been in place for some time and was due to one person who in the past removed the phone. We brought this to the attention of the provider who told us there had been on-going issues with the phone being removed by one person who challenged the service, but they are working with the local authority to review this person’s placement. They also said that they would look at other options to replace the phone in the home.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

We reviewed care plans for two of the four people living at the home. We saw that these had been reviewed. People’s preferences were recorded, including cultural and religious needs. We saw that one person who regularly attended a place of worship was supported by the service to do this.

Requires Improvement

Is the service responsive?

Our findings

People told us that the service took account of their choices. One person, who enjoyed swimming, told us, "I like swimming and staff take me." Another person told us they enjoyed doing a number of activities including playing football and snooker.

Each person living at the home had an individual activity plan. On the day of our inspection we saw in one person's care records that they needed staff to sit with them several times a day to allow them to discuss activities for that day. We saw that this had happened during our inspection. Another person had a shower installed to support them with their personal care needs.

However, staff were not always responsive to people's individual needs. We observed that one person using the service who was assessed to need 24 hour one to one care had been left unsupervised for periods throughout the day. This was despite their care plan stating that they should be provided with, 'one to one support at all times.' The care plan also stated that two staff members were required when going out in community or attending appointments. Staff told us that they sometimes went out in to the community with another person using the service as there were not enough staff to respond to this person's needs. Another person living at the home was keen to get a job and had been provided with a laptop to help them to search for one, however we were told by staff that they were unable to use this as the service did not have internet access. The provider subsequently submitted evidence showing that the internet had been installed prior to our visit.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us that they would speak with the manager about any concerns they had and felt confident that this would be acted on. We saw that the provider had a process in place for dealing with complaints. Staff were aware of the complaints policy and told us that people wishing to make a complaint were supported to do so. During our inspection we observed people entering the office based at a neighbouring location, to speak with the manager. The manager told us that there had been no complaints in the last 12 months.

Relatives we met during the inspection were known by staff and welcomed at the neighbouring home. We saw that staff offered one relative a drink and a private space to meet with their relative.

The manager told us that monthly 'residents meetings' were held at the service and people were encouraged to attend. However, this had not been regular. The manager told us that the last meeting was held In June 2014. However, minutes of these were not available as these had not been recorded. People we spoke with were unable to say whether they had attended a meeting.

Requires Improvement

Is the service well-led?

Our findings

People were asked their views about the service. We saw that the provider had asked people living at the service their views using a questionnaire. Staff had supported people where necessary to complete these. This covered areas such as food choices, privacy, staff, social activities and bullying. Most people had indicated that they were very happy living at the home.

Although the provider had quality assurance systems in place to audit and monitor the quality and safety of the service, these were not always effective. The quality audits covered all three services owned by the provider and managed by the new manager, including two neighbouring services. We saw that a yearly 'quality monitoring visit' check, conducted in July 2014, had stated that this service and the neighbouring service looked clean and tidy, however, this had not identified the infection control issues identified at our inspection the day after this quality visit had taken place. We saw that although other health and safety issues had been noted by the visiting manager, such as, water temperature recording. However, the provider did not identify health and safety concerns found on the day of our inspection. We saw that a monthly health and safety check carried out in June 2014 had indicated that there were no trip hazards in the communal areas, this had not identified trip hazards seen in the communal area seen on the day of our inspection.

We saw that an action plan had been developed by the provider following an audit in December 2013 and had highlighted various areas for improvement. For example, storage of medicines, the need for monthly medicines audits and infection control monitoring to be actioned by April 2014. However, on the day of our inspection we saw no evidence that these had been taking place.

The manager told us that monthly staff meetings were held with staff, the last in June 2014. We saw from these minutes that staff had discussed various areas regarding the running of the service, including an update on how to support people living at the home and staff responsibilities. We also noted that concerns about the standard of cleaning had been discussed and a plan was put in place to monitor cleaning at the home. However, we saw no evidence of this on the day we inspected.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Following a period of change, the provider had appointed a new manager in June 2014. Staff told us that there had been a lot of instability at the home for some time and this had started to improve when the new manager was appointed. One staff member told us One staff told us that the new manager was "very supportive and open," Another staff member told us that the new manager, "listens more." Staff told us that the new manager had made changes.

There was a system in place for dealing with incidents and accidents at the home. Staff told us that following an incident they would first report this to the manager or person on-call if at the weekend. They then completed an incident form and which was passed to the manger. However, some staff were unclear what happened to the form once this was completed. The manager told us that learning from incidents were discussed during supervisions and at handover meetings. Staff told us that there had been changes to the way they worked following a serious incident in May 2014.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not protected from the risk of inappropriate of unsafe care and treatment because the provider did not always meet people's individual needs. Regulation 9 (1)(a)(b)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People were not protected from the risk of inappropriate of unsafe care and treatment because the provider did not have effective systems in place to identify asses and manage risks relating to health, welfare and safety of people using the service. Regulation 10 (1)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The provider failed to protect people who use services and others from acquiring a healthcare associated infection. Systems were not in place to assess the risk of and prevent, detect and control the spread of a health care associated infection. Regulation 12 (1) (a)(b)(c) (2)(a)(c)(i).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

This section is primarily information for the provider

Action we have told the provider to take

People who use services were not protected against the risks associated with the unsafe use and management of medicines. Appropriate arrangements were not in place for safe keeping, dispensing and safe administration and disposal of medicines. Regulation 13 (1) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The provider failed to ensure at all times that there were sufficient numbers of suitably qualified, skilled and experienced staff employed for the purposes of carrying on the regulated activity. Regulation 22