Housing 21

Housing 21 – Cedar Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About this service
Housing 21 – Cedar Court provides care and support to adults living in specialist 'extra care' housing. At the time of the inspection, 38 people aged 55 and over were using these services. The service can support up to 40 people. People live in flats across three floors of the service that is located in the London Borough of Lewisham.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service
Medicines were not always managed safely. Records used by staff to confirm when people had their medicines were not completed accurately. Some medicine administration records contained unexplained gaps when people were scheduled to have their medicines administered. People were at risk of deteriorating health because their medicines were not managed safely to keep them well and manage pain. Medicine audits were completed by senior care staff, however, these checks did not find the errors we found.

Risks were not always safely assessed and mitigated appropriately. When staff handled people's money the financial records were not always accurate, increasing the risk of financial abuse.

People told us that the care workers were not always kind, compassionate or cared for them in a dignified way.

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.

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

Rating at last inspection and update
The last rating for this service was requires improvement (report published on 21 January 2020) and there were multiple breaches of regulations. This service has been rated requires improvement for the last three consecutive inspections.

Why we inspected
We undertook this targeted inspection to check whether the Warning Notices we previously served in relation to Regulation 12 and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. CQC are currently trialling targeted inspections, to measure their effectiveness in following up on a Warning Notice or other specific concerns. They do not look at an entire

key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

When we inspected people raised concerns that care workers were not always kind and caring, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe, caring and well-led. The overall rating for the service has not changed following this focused inspection and remains requires improvement.

Enforcement
We have identified breaches in relation to poor medicines management, how staff treated people when they were receiving care and support and the unsatisfactory management of people's money. We also found the governance systems were not effective and staff had not always treated people with dignity and respect.

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 continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below	**Requires Improvement**

Housing 21 – Cedar Court

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check whether the provider had met the requirements of the Warning Notices in relation to Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We widened the scope of the inspection to become a focused inspection which included the key questions of safe, caring and well-led in response to the concerns we found.

Inspection team
This consisted of one inspector and one Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built accommodation. The accommodation is rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

The service did not have a manager registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection visit was unannounced. Inspection activity started 25 February 2020 and ended on 3 March 2020. We visited the office location on 25 February 2020.

What we did
Before the inspection, we looked at information we held about the service including notifications sent to us. 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.

During the inspection
We spoke with six people using the service and two relatives. We spoke with the interim manager, deputy manager, another of the provider's managers and five care workers.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed. We completed general observations of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We did not receive any feedback from the professionals we contacted who were involved in the service.

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 inadequate. At this inspection this key question has remained the same.

The purpose of this inspection was to check if the provider had met the requirements of the warning notices we previously served. We assessed all of the key question. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

● Medicines were not always managed safely by staff. People told us they had their medicines when needed. They commented, "They give [medicines] to me and they take it out of the pack" and "Medicines are delivered from the pharmacy." Although people gave positive feedback about staff supporting them with their medicines, this is not the reality we found when we looked at people's medicines administration records (MARs).

● The provider told us they had an improved medicine ordering and delivery system in place to reduce the risks of people not having enough medicines. However, we found this system was not consistently effective. One person had run out of their medicines that helped to reduce the risks of choking due to a medical condition and this was not re-ordered. On the day of the inspection, a relative of the person went to the pharmacy to collect this medicine because they had run out of supplies, to help reduce those risks to their health. After the inspection the manager sent us information to show they had contacted the pharmacy to check whether the medicines were available for delivery. This contact was made two days after our visit and did not confirm the medicines had been previously ordered. Another person's (MAR) showed they had missed their medicines on three consecutive days because these 'were not available'. This meant that the improved service ordering and delivery system was ineffective because people continued to miss their medicines due to no availability.

● The MARs were not always completed accurately. One person's medicines chart indicated that two medicines were stopped by the GP. However, this was not signed and dated by the member of staff who made this change. This action would be in line with best practice guidance from the Royal Pharmaceutical Society. This person also did not receive their medicines on eight occasions in the month of January 2020, no explanation for this was provided. We looked at the MAR for a second person. Their MAR had 14 medicines listed, but no staff signature for seven of them during four weeks in January 2020. A third person's medicines administration record (MAR) included Warfarin. The MAR did not record the current dose of the medicine to be administered. This is critical information for staff because Warfarin doses are dependent upon the blood test results. However, this information was missing. This practice showed that staff did not follow the guidance from the Royal Pharmaceutical Society on the management of medicines in a social care setting. We found a further two MARs where staff had not signed the records when they supported people.

● People did not have routine reviews of their medicines when this was required. In January 2020 two people had consistently declined to take their medicines. This pattern of refusing medicines was not

identified by staff and they had not supported the person to seek medical advice or a medicines review.
● The manager had systems in place for regular reviews of MARs but this was not completed robustly. We looked at the audits from November 2019 to January 2020, we saw that these audits had not identified the issues we found in some of these MARs. These audits were in place to ensure staff were providing support for people to take their medicines and as prescribed. The deputy manager told us that the audits were completed, and the interim manager would review these to ensure these were accurate.
● We could not be confident all eligible staff were safe to administer medicines to people. The provider assessed the competency of all staff to ensure they were safe to support people with their medicines. At the previous inspection we found that three newly employed members of staff had not fully completed their medicines training or medicine competency assessments. At this inspection one member of staff had three medicine competency checks in place. However, we found that the critical information regarding their competency to support people with their medicines unsupervised was not commented upon. Neither of the three competency assessments were signed or dated by the member of staff who observed the assessment. During the inspection we showed the interim manager, deputy manager and one of the provider's managers details of all the concerns discussed above. We were told that we would receive an update of each of these concerns. We did not receive all of the feedback as expected.

These issues were a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● There were systems in place to complete assessments to identify and manage risks. Staff identified risks associated with people's health and wellbeing including mobility, medical conditions, eating and drinking and mental health needs. These assessments were on people's care records and these had been updated when changes occurred. However, we found staff had not identified the potential risks associated with handling people's money.
● People were at risk of financial abuse because their financial records were not completed accurately. Three people gave staff money to complete shopping for them. On each occasion the till receipts did not match the information that was recorded on the provider's financial transaction form. On two occasions there was money unaccounted for and on two other occasions staff used their own money. People's financial records did not show how the monies and receipts were reconciled because the spending and balance returned did not match. During the inspection we were told that we be updated about each of these concerns. We did not receive any feedback. The failure to have effective systems in place to manage people's finances safely, increased risks of financial abuse. Because of these concerns we have raised a safeguarding alert with the local authority safeguarding team. After the inspection we received an action plan which outlined the provider's intention to introduce a more robust system to audit financial transactions. At the time of writing this report this had not been implemented therefore we could not comment on the effectiveness of this system.
● There were risks associated with people's home environment that reduced their ability to be independent. Two people we spoke with said that they were unable to move around their homes independently and without assistance. For example, one person who used a wheelchair was unable to leave their home without assistance because their front door was heavy for them and they could not manoeuvre their wheelchair and open the door to leave. Another person was unable to leave their home due to reduce mobility. Comments included, "I can't open my door and I have to press my buzzer for someone to open the door for me. I tell them it's annoying having to wait" and "Difficulty opening the door if (family member) is not here I struggle to get out." During the inspection we discussed these concerns with the managers. They confirmed that they would investigate making changes to front doors where people had experienced issues. After the inspection we did not receive any feedback regarding these concerns.

These issues were a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● The rota showed there were enough members of staff available to meet people's needs. People gave us mixed views of the levels of staff at the service. They said, "They could do with two staff at night, there is only one. It takes two people to move me but at night only one. It's quite hard for them. During the day it's alright, I'm a double up", "Yeah there is [enough staff] we get staff who actually work here and some agency" and "They've had a lot of problems with the care staff." Staff told us they were satisfied about the level of staffing. Staff said, "Things are a lot better here with staff" and "No issues. There was an on-call system people could access in an emergency."

● Suitable staff were recruited through a robust recruitment process. Pre-employment checks were completed before staff worked with people. The checks included job references, proof of the right to work in the UK and a criminal record check with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working in care services. We did find one file which did not contain the member of staff's DBS. The managers said the DBS could be with the recruitment team and they would provide us with an update following their investigations. We did not receive any update at the time of writing this report.

This issue was a continued breach of Regulation 17 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● Staff followed the provider's infection control processes to help reduce the risks of infection and to ensure the service was clean, odour free and hygienic.

● The service had enough supplies of personal protective equipment (PPE). PPE is protective clothing or equipment designed to protect staff from infection. Staff used gloves and aprons to help reduce the risk of infection and cross contamination.

Learning lessons when things go wrong

●The manager monitored the service for opportunities for learning. Records showed that accidents and incidents that occurred at the service were monitored. These records allowed the manager to review these incidents and identify any trends or patterns.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect. At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

The purpose of this inspection was to check if the provider had met the requirements of the warning notices we previously served. We assessed all of the key question. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People said staff were not always supportive or treated them in a caring way. People gave mixed views on whether staff treated them with respect. They said, "Staff are friendly chatty, they are nice", "I always talk to them when they give me a shower this makes me feel reassured", "What I don't like is when they shout. They think I'm deaf" and "I want them to listen to what I've got to say instead of shouting me down when I try to tell them something, I don't need to be shouted at." We gave the managers this feedback from people. The interim manager confirmed they were aware of how some staff communicated with people and they had plans to address these concerns.

These issues were a breach of Regulation 9 (Person centre care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had some understanding of how to support people's needs as described in the Equality Act (2010). Care records contained information such as any cultural, disability, religious and identity needs and staff were aware of these. People said, "I go to the church in the day centre" and "They get me ready to go to church with dial a ride."

Supporting people to express their views and be involved in making decisions about their care

- People were involved and contributed to care assessments. Assessments captured people's needs and the decisions they made about their care and support. One person said, "They did an assessment and came to where we used to live."
- Staff completed reviews of people's care and support needs. However, we found staff did not always use people's information to provide them with appropriate care to meet their individual needs.

Respecting and promoting people's privacy, dignity and independence

- People said some staff supported them in a way that gave them privacy. They confirmed that personal care was carried out in the privacy of their own bathrooms which helped to protect their dignity.
- People maintained their independence as much as possible and went out with relatives and friends into their local community for lunch and to celebrate their birthdays.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

The purpose of this inspection was to check if the provider had met the requirements of the Warning Notices we previously served. We found additional concerns regarding a specific concern we had about the management of the service.

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

● People did not always find the service was well managed. People were unclear about who was managing the service. People commented. "I think it's good they do their best", "I think things could be better", "There is no point ringing the bell there is no one to come back everyone busy" and "Sometimes I feel really bad even those in the office don't come out and spend five minutes with me." and "There isn't a manager at the moment." The feedback from people showed that staff did not always provide them with care and support that provided good outcomes for them.

These issues are a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had communicated better with staff which helped to improve staff morale. From our discussions with staff they told us their confidence had improved. Staff were very complementary about the managers who were providing support. Staff said, "The rota was well staffed and each allocation is covered" and "I now enjoy coming to work."

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 provider had monitoring systems in place to check the quality and safety of the service. However, these systems were not always effective because the checks on people's financial records and medicine administration records were not robust enough to identify errors and take immediate action to resolve them.

● There was no overall ownership, oversight or clear leadership at the service. The previous registered manager was no longer employed at the service. At the time of the inspection two of the provider's managers were providing support to the service. People commented. "[The manager] is helpful and supportive and has put a smile on my face" and "Since [the manager] arrived she/he has tried to put things

right."
● The provider had developed an action plan to make improvements to the service. Some improvements had been made regarding the quality of care records including care plans and risk assessments. Senior staff completed regular spot checks and observations. Any issues or concerns were recorded and discussed with the members of staff concerned. However, we found the senior managers were reactive to the concerns we found rather than having insight to the service and acting proactively. While there was evidence of some improvement in response to the findings in the previous report, not enough action had been taken to ensure the service was consistently managed well.

These issues are a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider understood their responsibilities regarding the duty of candour and to share information when concerns were raised or when things went wrong. Staff reported safeguarding incidents with the local authority and reported and shared incidents on their internal reporting systems for review by senior managers to implement actions for improvement where necessary.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were asked for their feedback about the service including the care and support they received. People gave positive and less favourable comments about their experiences of the service. People said, "Some [care workers] will come and talk thinking I can't hear anything and shout" and "[Some care workers] need a little more training than others [some are] rude in their approach." The response to the last service users annual survey was low and only two people responded. They said they were generally happy with the care and support received. However, the feedback we received was in contrast to those survey results.
● The manager sent notifications to the Care Quality Commission (CQC). This provided CQC with details of concerns, so action could be taken promptly as required.

Continuous learning and improving care
● There were systems in place at the service for learning and development. After the previous inspection the senior management team had developed and implemented a plan for improvement of the service including investigating staff concerns. As a result there were staff engagement meetings and group and individual interactions were conducted with staff. This had resulted in a positive outcome for staff and had improved the culture of the organisation. Staff told us, "The [interim manager] has turned the service around" and "Overall things are better and we have more staff."
● Staff did not always work collaboratively with people to help them maintain their health. Staff failed to ensure medicine management systems were robust to ensure people had access to their medicines when required.
● People said staff did not always work in partnership with them to help maintain their well-being. People commented, "[Staff] keep putting me in the wheelchair instead of making me walk", "Sometimes I don't have a carer, they don't turn up and they don't say they not coming" and "I want to go toilet they say it's not your time yet and I've asked how long have I got to wait." The comments from people describe that staff were not accommodating to people's individual needs and did not always provide care and support to meet those needs.

Working in partnership with others
● Staff had developed working relationships with key health and social care services. Staff worked in partnership with the local authority safeguarding and care commissioning teams as well as clinical

commissioning groups. This partnership working helped people to received co-ordinated and joined-up care.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to design care or treatment plans for service users' to ensure their preferences and needs were met; The provider failed to ensure people received consistent care to meet their care needs. Regulation 9(1)(a)(b)(c)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure people received safe care, treatment and management of their medicines. The provider failed to ensure there were robust systems in place to manage people's finances safely. Regulation 12(1)(2)(b)(c)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure audits were completed accurately and failed to maintain accurate records for all people using the service. Regulation 17 (1) (2) (a) (b) (c)