London Care Limited

London Care (Chestnut House)

Inspection report

209 Arabella Drive
London
SW15 5LH

Date of inspection visit:
18 December 2018
20 December 2018

Date of publication:
27 February 2019

Ratings

Overall rating for this service	Good

Is the service safe?	**Good**
Is the service effective?	**Good**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Summary of findings

Overall summary

We inspected London Care (Chestnut House) on 18 & 20 December 2018. This was an announced inspection. The provider was given 48 hours' notice because the location is an extra care housing scheme; we needed to be sure that someone would be in.

At our previous inspection on 27 November and 6 December 2017 we found the provider was not meeting regulations in relation to the outcomes we inspected, we found a breach of regulation in relation to Safe Care and Treatment. The service was rated Requires Improvement.

At this inspection, we found the provider had now met the breach identified at the last inspection. We also found improvements had been made in relation to record keeping. Therefore, the rating for the key questions 'is the service safe?' And 'is the service well-led?' has improved to Good. However, the rating for the key question 'is the service caring?' has deteriorated to Requires Improvement following feedback from people.

London Care (Chestnut House) provides personal care and support to people living in an extra care housing scheme. This consists of 42 individual flats within a staffed building with some communal areas. At the time of our inspection there were 33 people using the service. A separate organisation was responsible for managing the building and flats. Each flat consisted of one bedroom, a lounge/kitchen and a bathroom and was individually furnished.

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Feedback from people was mixed, although some praised the carers for their caring attitude, others said that their care sometimes felt rushed and care workers did not always engage with them or go over a basic level of care.

People said they felt safe in the presence of care workers who supported them with their medicines and meal preparation. Care workers demonstrated a good understanding of people's needs and were aware of which people needed more help and support than others. Carers also demonstrated an understanding of people's preferences.

People lived independent lives and, those that were assessed as being able to, managed their own medicines, meals and also their health care needs.

Staff received training that was relevant to the needs of people using the service. They also received regular mentoring through office based and 'field' supervisions based on certain themes such as medicines.

People had signed tenancy agreements and consented to various aspects of their care. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Care plans were completed in the presence of people and were focussed on maintaining a good quality of life, mainly around personal care, safe medicines management and a healthy lifestyle.

Where people had raised any concerns or formal complaints these were investigated by the provider. Similarly, incidents and accidents were documented. Follow up actions in relation to complaints and accidents were documented and there was evidence that the provider took action where needed to try and make improvements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service has improved to Good.

Risk assessments were completed appropriately with the level of risk identified and plans were in place to manage the risk.

People told us they felt safe living at Chestnut House and staff were aware of reporting procedures in relation to any concerns or incidents.

People received their medicines as prescribed.

Safe staff recruitment procedures were followed.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Requires Improvement

The service had deteriorated to Requires Improvement.

Although people told us that staff were caring, many felt that the care they received was sometimes rushed.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Good

The service has improved to Good.

Improvements to record keeping in relation to follow up actions following feedback from people, daily and maintenance records had been made.

London Care (Chestnut House)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We gave the service 48 hours' notice of the inspection visit because it is an extra care housing scheme; we needed to be sure that someone would be in. The inspection took place over two days, 18 and 20 December 2018.

The first day of the inspection was carried out by one 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 care service. On this inspection, their area of expertise was care in the community. The second day of the inspection was carried out by one inspector.

Before the inspection, we reviewed the information we held about the service. This included notifications sent to us by the provider and other information we held on our database about the service such as the Provider Information Return (PIR). Statutory notifications include information about important events which the provider is required to send us by law. A PIR is a form that requires providers to give some key information about the service, what the service does well and improvements they plan to make. We used this information to plan the inspection.

During the inspection we spoke with 11 people using the service, five staff, including the registered manager, care co-ordinator and care workers. After the inspection, we contacted four health and social care professionals about their views of the service. We received feedback from two of them.

We reviewed a range of documents and records including; six care records, three staff records, as well as

other records related to the management of the service such as complaints and audits.

Good

Is the service safe?

Our findings

At our previous inspection which took place on 27 November and 6 December 2017, although risk assessments were in place, they were not always completed appropriately and the level of risk was not always accurate. We found that the risk assessment ratings were not being calculated correctly which meant there was a risk that people were not receiving the appropriate support as stated in their risk management guidelines.

At this inspection, we found improvements had been made in relation to risk assessments.

Since the last inspection both the registered manager and the care coordinator had attended refresher training in care planning and risk assessment. The registered manager told us that risk assessments had been reviewed by herself or the care coordinator for each person to ensure all risk assessment scores were calculated as required. We reviewed a sample of care plans and risk assessments which showed that risks to people were scored appropriately. Some of the areas that people were assessed in included the risk of falls/mobilising, skin Integrity and environmental risk. There were other individual risk assessments in place if people presented with certain medical conditions, for example, risk of choking. A risk rating of high, significant, medium or low was given based on various contributing factors. Risk assessments included steps that needed to be taken to reduce the risk, following which the risk was recalculated. For example, people that were at high risk due to poor skin integrity had management plans in place that included maintaining high levels of personal hygiene, encourage mobility and good nutritional intake, record any movements on repositioning charts. There were similar risk management steps for those people at risk of falls.

Risk assessments were completed in relation to medicines management. People were assessed according to their level of independence in relation to medicines support. One person said, "The medicines are kept locked up. The carers give them to us. It's all written down in a book to tell them." People who could manage their own medicines were able to do so. Staff completed medicine administration record (MAR) charts for those that were assessed as needing some assistance. We reviewed a sample of MAR charts and saw that these were completed appropriately. We also observed a member of staff supporting a person to take their medicines in a safe way. They asked the person for their consent before giving them their medicines and respected their decision when they declined, noting this down on the MAR chart correctly.

Guidance notes were available advising staff how to complete incidents and accidents records. This included details about how to deal with them, clarification of what is needed and who to report to. Records were kept of every incident and accident that had occurred in the service, this included an investigation report. Each report included details of the person involved, what happened, whether notifiable and to who, how the investigation took place, findings, corrective and preventative action, follow up and resolution. Appropriate recruitment checks were in place. These helped to ensure only suitable care workers were employed. Staff files included evidence that checks had been carried out before staff were employed. This included an application form, a literacy and numeracy test, an employee health questionnaire, references, proof of ID and Disclosure and Barring Service (DBS) checks. The DBS provides criminal record checks and

barring functions to help employers make safer recruitment decisions.

People we spoke with said they felt safe in the presence of staff. One person said, "There's no nastiness or bullying." One relative said, "The carers use the hoist properly and [my family member] feels safe." Care workers were aware of what steps they would take to keep people safe and how they would report any safeguarding concerns. Training records showed refresher training in prevention of abuse was provided to staff. Safeguarding records showed that where concerns were raised, the service worked with the local safeguarding teams to investigate them and act where appropriate.

A housing association was responsible for the maintenance of the building and for carrying out appropriate checks. We saw that an estate's inspection and a fire risk assessment had been completed by the housing association. This covered many health and safety areas including both internal and external checks. Staff had received training in infection prevention and control and exercised infection control practice when supporting people.

Good

Is the service effective?

Our findings

People using the service told us that staff helped them when they needed help with their meals and they were satisfied with the support they received. One person said, "I have staff cook for me, I had some toast today." Another said care workers satisfactorily prepared any food that they asked for. A third said they cooked food themselves but they also put food out on the counter tops sometimes for care workers to prepare.

People's preferences in relation to their eating and drinking were included in their care plans. Some of the examples that we saw included "I like freshly prepared meals and ready meals" and "I like chicken, porridge oats. Dislike spicy food." People's level of independence in relation to preparing and cooking meals were also recorded and care workers were familiar with people's individual support needs.

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.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. We checked whether the service was working within the principles of the MCA. Care workers were careful to ask for people's consent when supporting them, from asking permission before entering their flats, to supporting them with food or medicines. Any medical conditions impacting on people's decision-making capabilities were also documented.

The provider had recorded people's consent with regards to access to their flats, their postal mail and for the use of bed rails. We saw copies of assured tenancy agreements which included details of fees and rights in terms of ending the tenancy. Tenancy agreements were completed directly with the housing provider. Tenancy agreements were signed by people or in their best interests by family members.

New tenants moving in were given the opportunity to come and see their flats and make an informed decision about whether they wanted to move in. Pre-admission assessments were completed which helped to ensure that placements were suitable, these were completed in the presence of a social worker.

People told us their general health and medical needs were being met. They told us they had appointments with their optician, chiropodist and physiotherapists. During the inspection, we saw healthcare professionals such as therapists and nurses coming to visit people. Care records included correspondence such as GP referrals, appointment letters and hospital discharge notes. We also saw evidence of the GP being contacted when people were unwell. Medical conditions that could have an impact on people's care and support were documented for staff to see.

Care workers told us they were happy with the training they received. New starters received an induction

during which they were provided with training in a number of areas relevant to the needs of people using the service such as safe eating and drinking, supporting mobility and movement, support with washing and dressing and medicines management. Learning from each topic was signed off by the registered manager either through completion of workbooks, observations and/or shadowing. The registered manager maintained records for monitoring training which showed that staff received training in mandatory areas such as food hygiene, first aid, nutrition and healthy eating, administration of medication and Mental Capacity Act.

Staff received regular supervision. These were either office based or done whilst they were supporting people, to see if they were able to carry out their roles as required. Themed based supervisions in specific areas such as medicines administration was also done to ensure these areas of practice were safe.

Requires Improvement

Is the service caring?

Our findings

Feedback from people was mixed. Some people praised the carers and told us they were caring and friendly, whist others were less complimentary.

Some of the more negative comment were in relation to care workers not always having the time to provide care other than the basic minimum and not always being informed about the time they would be coming. Comments included, "80% of them are good. It varies", "The carers are polite and kind but they don't have the time to chat", "[The carers] should stay half an hour to give me breakfast and a shower but if you're finished before [that time is up] they go", "They just do what they've got to do and then they go", "The standard of care has gone down. There are five good carers; the rest are bad, they are not interested. Good carers come on time, bad don't", "Sometimes the carers come late at 10:00am instead of 07:45 or 08:00", "Basically on time. Sometimes they're late. If it becomes a regular pattern on lateness I get cross" and "I pull the cord and complain sometimes [if the carers are late], sometimes they will come [in response]."

We raised this with the registered manager after the inspection and she advised that staff were reminded about this during meetings. In the staff meeting minutes that we reviewed it was acknowledged that care was being rushed and that some care workers were rushing when doing care tasks, mainly in relation to domestic chores. Staff were reminded about their duty of care when supporting people. We reviewed staffing rotas over a two week period prior to the inspection, we did find occasions where the staffing levels were one care worker down from the usual levels. However, we received reassurance from the registered manager and saw staff signing in sheets that these gaps were completed with staff from other services or either herself or the care co-ordinator.

Some of the positive comments included, "[Care worker] is one who helps me, when my [family member] died she helped me a lot through that", "So far everybody has been very helpful and kind. They are very respectful. They always have something good to say to me. They are always cheerful", "I think [the care I receive] is very good. Most of the carers are kind and polite", "I think the care is quite good, the carers are very good and quite helpful" and "They look after me very well"

Care plans contained a section call 'my life story' which was completed in the records we saw. Care workers that we spoke with demonstrated a good understating of the people they supported, their preferences and their support needs. People using the service told us that care workers respected their privacy. One person said care workers asked permission before entering their flat and closed the curtains when they washed them. We observed staff seeking consent prior to entering people's rooms. A care worker told us, "Some people may feel uncomfortable so you need to make them feel at ease and peace. I don't want to take their independence away from them so let them do as much as they are able to."

Care workers received training in dignity and respect and equal opportunities. They were aware of the importance of treating people equally and with respect, being sensitive to any religious and cultural needs. Care plans included a section for people to express any individual needs. People were kept informed about any ongoing events or updates about the service through a newsletter.

Good

Is the service responsive?

Our findings

People that we spoke with said they did not have to raise any formal complaints. One person said, "I don't have any complaints. All the girls have been very kind to me." There was a complaint register which recorded all complaints that had been received. Since the last inspection, there had been seven recorded complaints. Records showed that these were logged correctly and investigated appropriately. These had all been resolved within reasonable timescales and action taken where improvements had been identified to mitigate from further complaints being made.

There was some activities provision within the service. This included a coffee morning, exercise, sing a long, reminiscence, bingo and knitting classes. A newsletter for people detailed the activities that had been arranged in the past and upcoming ones which included a Christmas party and meal. Previous one-off events included an Easter party with an entertainer, a BBQ and visitors from the Royal Albert Hall. The registered manager kept an attendance list for all the activities that had been held.

People led independent lives and we saw people freely leaving and coming back to service throughout the inspection. One person said they went to a day centre and that the carers made sure they were ready. Some people felt that the quality of the activities within the service could be better. Comments included, "We do exercises on Tuesday", "I go to Bingo on Thursdays and the Quiz on Friday. It would be nice to have something at least three days per week" and "We talked about the Sing-a-long [activity]. We don't have that anymore."

Care plans were outcome focussed. Typical examples included 'I want to manage my toilet needs and maintain good skin', 'maintain good health by eating well and drinking lots of liquid', 'I want to always look clean and smart' and 'to live in a clean environment'. Each care plan included how care workers could check that their goals had been achieved.

Care plans also included a section called communication needs, this gave staff some guidelines on any medical conditions that people had that affected their communication, for example a stroke. They also gave guidance on how people gave their consent and how they communicated and how staff could communicate more effectively with them, for example by writing things down, speaking slowly and clearly.

Supplementary information such as food charts, turning charts and daily notes were completed by care workers which gave a documented record of the support that people received. People had signed their care records to indicate they had agreed to their content.

Good

Is the service well-led?

Our findings

At our previous inspection which took place on 27 November and 6 December 2017, we found some aspects of the record keeping could be improved. Although tenants' meetings were held, there had only been two recorded minutes seen from April 2017 and November 2017. Although actions had been identified for staff to follow up, it was not clear from the minutes if these actions had been followed up. The manager told us that moving forward she hoped the tenant meetings would take place every three months and response to actions clearly recorded.

We also found that a repairs/maintenance book was not always updated with the action that the provider took following any maintenance issues that were raised. It was not always clear from the book if the issues recorded had all been resolved satisfactorily. In some cases, the monthly report books that care workers completed were not being completed appropriately.

At this inspection, we found that improvements had been made.

Tenant Meetings took place four times a year and actions points were documented on an action plan log and followed up by staff. Six people had come to the most recent tenants meeting along with the registered manger, care coordinator, team leader and a representative from the housing landlord. Some of the issues discussed included housing, complaints, health and safety, and activities provision.

The registered manager had changed the way the maintenance book was completed. A monthly maintenance log had been put in place and was reviewed monthly to ensure that any maintenance issues were followed up.
The registered manager had amended the turning and nutrition and fluid charts after consulting with the community nurses and using their templates. We reviewed some of these and saw they were being completed correctly. Monthly report books were checked by a senior staff member monthly to ensure the documentation was correct.

The registered manager was a visible presence at the service. Her office was located near the main entrance and she made herself available to speak with any people, relatives or visiting professionals. We saw people coming in and out of the office, speaking with her telling them about their day.

Staff told us they felt supported by the registered manager and they worked well as a team, helping and supporting each other. Team meetings were held every two months and staff used this as an opportunity to pass information to the staff team but also for the staff to raise any issues or concerns. Some of the agenda items included learning and development, organisation learning and best practice, health and safety and any specific branch business such as annual leave and medicines management. A care worker said, "I feel supported, there are opportunities here. When we have staff meetings, [The registered manager] always tells us what [training] courses are coming up."

A regional manager completed quality assurance audits known as a 'branch visit record.' We saw that when

areas of improvement were identified, the registered manager took action and these were checked during follow up audits.
The care co-ordinator visited people and completed quality assurance visits looking at the record keeping, feedback about the care workers, the general service management and the overall quality. On site spot checks were also completed when care workers were supporting people to check their standard of care provided.

The monthly home care record books were brought back to the office and signed off by the registered manager. Any errors that were identified, for example in the medicines records charts were followed up with the relevant care worker. Similarly, any practice issues that were identified during spot checks were followed up with themed supervisions. Office based supervisions were held in response to concerns raised.