London Care Limited

London Care (Chestnut House)

Inspection report

209 Arabella Drive
London
SW15 5LH

Date of inspection visit:
27 November 2017
06 December 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 27 November and 6 December 2017 and was announced.

This was the first inspection of the service since it registered with the Care Quality Commission.

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 39 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 new manager at the service who had submitted an application to become registered. 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.

People using the service were happy with the care and support they received. They said they felt safe in the presence of care workers who were friendly and caring. We observed care workers speaking to people in a polite manner and supporting them with their medicines and they did so appropriately, taking their consent and recording on the MAR charts.

People were satisfied with the support they received with regards to their nutrition. The majority of people had their shopping done by relatives or ordered in ready meals that were delivered to their flats. Staff supported them to prepare their meals.

We found that although risk assessments were in place, the level of risk was not always documented correctly and therefore there was a potential risk of the necessary support plans not being in place. We also found other areas of record keeping were not always completed in sufficient detail.

Recruitment checks were robust and there were enough staff to support people. We found that staff received a thorough induction and the necessary ongoing mandatory training. They received regular one to one supervision.

People told us they knew how to raise any concerns. The provider recorded complaints on their online reporting system and carried out investigations into complaints received, taking action where necessary and addressing the concerns of the complainant.

Thorough quality assurance checks, including audits and feedback surveys were in place. There was an action plan that the provider had in place in response to issues found in audits.

We found a breach of the regulations in relation to safe care. You can see what action we have told the provider to take at the back of the full version 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 Safe in all aspects.

Although risk assessments were in place, they were not always completed appropriately and the level of risk was not always accurate.

People using the service told us they felt safe in the presence of staff.

There were enough staff to support people and staff recruitment procedures were robust.

People were supported to take medicines. Auditing procedures for medicines were thorough in identifying and acting on concerns.

Is the service effective?

Good

The service was effective.

Staff received appropriate training and supervision.

People received adequate support in relation to their nutrition.

People consented to their care and treatment and staff supported them to make choices.

Is the service caring?

Good

The service was caring.

People said care workers were friendly and kind.

People told us they were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

Individual care plan and support plans with outcomes for people were in place.

The provider recorded any complaints received and acted upon them, responding to the complainant and carrying out investigations into the complaint.

Is the service well-led?

Requires Improvement

The service was not well-led in all aspects.

Some aspects of record keeping were not always appropriately documented.

Quality assurance checks were effective in picking up concerns.

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 checked 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.

This was a comprehensive inspection and took place on 27 November and 6 December 2017.

The first day of the inspection was unannounced, the provider knew we would be returning for the second day. 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 older people care services.

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. Statutory notifications include information about important events which the provider is required to send us by law.

During the inspection we spoke with six people using the service. We also spoke with two care workers, the manager, a team leader and the regional manager.

We checked records related to the management of the service. These included four care plans, three staff files, training records and audits.

Requires Improvement

Is the service safe?

Our findings

We found that the risk assessments 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.

The falls/mobilising risk assessment scored different areas to give an overall risk score. One person had been scored as low risk when according to the risk score guidance they were at significant risk. For this person, A MUST score to give a risk rating in relation to nutrition was incorrectly scored as low risk when it should have been moderate.

In another care plan, the falls/mobilising risk assessment was scored as a moderate risk when according to the risk evaluation it should have been significant. This person was identified at being at high risk in relation to their skin integrity. The action according to the risk guidance was to reposition the person at every visit and for them to have a care plan to manage this. In November 2017, they had been assessed for pressure ulcers and the district nurse had requested for them to be repositioned every three hours. We saw the repositioning charts for this person and from the records we were unable to tell if the person had been repositioned as per the guidance. We showed the charts to both the team leader and the regional manager. Following the inspection, the provider submitted new turning charts that they would be using in future to enable them to record these actions better.

Some aspects of the environmental risk assessment were not scored correctly either.

The above identified issues demonstrate a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service told us they felt safe. Comments included, "I feel safe now", "I'm not allowed a bath on my own – they worry that I'll hurt myself. I suppose it's for my own safety."

Care workers were familiar with safeguarding reporting procedures and how they would identify potential signs of abuse. A care worker told us, "Safeguarding could be financial, physical or emotional. I would have to tell if someone confided in me. I would report it to the manager." A safeguarding information poster, with information on how to report concerns was available in the main office and in the staff room.

A care worker told us, "They called me in for an interview. I had to bring in proof of ID and address." Staff files contained evidence of the required pre-employment checks such as right to work, identity, references and a Disclosure Barring Service (DBS) check. The DBS provides criminal record checks and barring functions to help employers make safer recruitment decisions.

There were eight care workers on shift on the first day of the inspection. The manager told us the usual staffing levels were for eight care workers in the morning, five in the afternoon and two waking care workers at night. We saw the operational team staff rota which included the manager, team leader and the scheme coordinator and saw at least one of them was on duty during the week. Rotas for care workers indicated that

the staffing levels prior to the inspection were as stated by the manager. People we spoke with did not raise any concerns about not being able to get hold of care workers. They said, "You can get help anytime by pressing your button" and "The pull cords are good. One on me and one on the wall. If you press a carer answers, asks you what you want and then comes to see you."

A medication risk assessment containing details of the pharmacy, how people were supported with medicines and consent for authorising staff to support them with medicines was in place.

We observed two care workers supporting people with their medicines and they did so competently. Asking people for their consent, checking which medicines were to be given and completing Medicine Administration Record (MAR) charts after people had taken them. MAR charts were contained within monthly workbooks that were completed by care workers. These were bought back to the office for auditing and any errors identified were acted upon.

Errors relating to medicines administration were recorded on an online reporting tool called Branch Reporting System (BRS). There were 16 recorded medicines errors in 2017. Some of these were in relation to a single missed dose or the wrong dose given. Where these errors had been identified, the provider took action and sought the advice from a GP and in some cases carried out a themed supervision which included a competency assessment in medicines administration for the care worker in question.

Checks to monitor the safety of the environment were carried out on a regular basis. An estates inspection had been completed in October 2017 which included fire safety, external and internal checks. Actions had been assigned for the provider and the housing association to follow up on. We went through these with the manager on the day of the inspection and she confirmed they had all been acted upon or were in the process of being resolved.

We saw that the service had been checked for the presence of legionella. We also saw an up to date water risk assessment which included monitoring the temperature of water.

Good

Is the service effective?

Our findings

People using the service were supported by staff who received regular training.

A care worker told us, "Induction was five days, we had to complete some workbooks we did moving and handling, infection control, safeguarding and lots of others."

New care workers completed a five day induction which covered The Care Certificate. The Care Certificate is an identified set of 15 standards that health and social care workers adhere to in their daily working life. It is the minimum standards that should be covered as part of induction training of new care workers and was developed jointly by Skills for Care, Health Education England and Skills for Health. Care workers completed a number of workbooks as part of this to test their knowledge on the topics covered.

Mandatory training was covered as part of the induction and refreshed on a yearly basis. This included first aid, moving and handling, safeguarding and health and safety. Additional training was available as required based on the individual needs of people using the service and included diabetes, stoma care, dementia, challenging behaviour, nutrition and healthy eating.

An online reporting system was used to monitor staff training. This gave out an alert and produced a report for training that was due to expire. On the first day of the inspection, this showed that four care workers were due refresher training and we saw evidence that this had been booked for them.

A number of information posters were on display in the staff room including nutrition/hydration, pressure ulcers, continence and respecting privacy amongst others.

Staff files contained evidence of both office-based and on-site spot checks. Office-based supervision provided an opportunity for discussion in relation to employment issues, health and safety and other any work related matters. The on-site spot check consisted of general practice, care and support tasks, medicines management, recording and reporting.

Most residents chose to eat in their flats with care workers supporting them by microwaving meals and plating. Staff told us the majority of people either had family members bring in food or purchased ready meals through a delivery company that were delivered directly to their flats. There were opportunities to eat in the communal areas but on the day of the inspection, the majority of people ate in their flats. Comments included, "I much prefer to eat in my room", "Dinner is a surprise – I don't know what I'm going to have but I suppose I like everything that's there", "I decide what I want to eat – it's all frozen. Sometimes I do something for myself but mostly I let them."

Staff told us that relatives usually brought in food for their family members. There was also a home food delivery service available for people to use to have food delivered to their flats.

People's preferences in relation to their nutrition, along with any medical conditions that affected their

nutrition such as diabetes and how much assistance they needed with eating and drinking was recorded.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

A MCA information poster, with information on how to report concerns was available in the main office and in the staff room.

Staff understood issues around consent and were aware of the importance of seeking and respecting people's right to choose how they wanted to be supported. A care worker told us, "If someone refused medicines or personal care, I would respect their wishes but try and convince them and make them understand." Others said, "You have to get their consent even if it's written in their care plan. People have a right to say no" and "MCA is when someone cannot decide for themselves. You can't decide for them but you try and give them options and speak with other people like the social worker or relatives."

Care plans had documented people's consent for staff to access their flat, their mail and their consent to the use of bed rails. They also contained a section called communicating with others and if they were able to give verbal consent and if there were any impairment to their understanding. Details of how care workers could communicate with them and any difficulties with memory and coping mechanisms. If people needed support to make decisions, details of people to consult in best interests meetings were recorded.

Care plans contained a section for personal information including details of people's GP and their district nurse if applicable. A section to record their medical or health conditions was also included. There was evidence that people were supported to attend medical and health appointments through letters, optical prescriptions and discharge summaries.

Good

Is the service caring?

Our findings

People using the service were happy with the support they received from staff. Comments included, "These girls are OK", "I like the girls", "I have high praise for those two girls (carers named) as they sing and chat and talk to everyone" and ""I'd soon tell them if they were doing something wrong – they are alright, quite gentle." Interaction between staff and people using the service was appropriate, care workers spoke to people in a friendly and respectful manner.

People lived in their own flats and any personal care was carried out in the privacy of people's own flats. Care workers were aware of the importance of respecting people's privacy and we observed them knocking or ringing doorbells before entering flats. A care worker told us, "Small things can make a difference, like not exposing the whole body, making people feel at ease."

Each flat had a side window alongside the front door. Although some flats had net curtains or frosting on the side windows, others did not and we did see on occasion personal care being carried out as we were walking along the corridor. We highlighted this to the managers during the feedback at the end of the inspection and reminded her of the importance of telling care workers to close the bedroom doors when delivering personal care. None of the people we spoke with expressed any concerns with this, one person said, "Makes me feel less shut in."

People's independence was supported where appropriate. There was a laundry room available on the ground floor for people to use if they wanted, otherwise they received staff support. People said, "I know what I like to wear so they help but they don't decide what I'm wearing. If I'm going out they tell me if it's going to be cold or wet" and "They sort my laundry out – hang it in my room, it's never a problem and good to have help." All the flats had a shower room, however if people preferred a bath one was available on the ground floor with hoist facilities.

Care plans contained details of the personal care support needed and also other person centred information. This included details of people's life histories, preferences in relation to their nutrition and also how they liked to communicate. Cultural and spiritual needs were also included. Staff were aware of the importance of respecting cultural needs and treating people with respect.

Good

Is the service responsive?

Our findings

People and their relatives were given the opportunity to visit the service following a referral to see the facilities on offer and speak with the relevant staff.

Each person had a care and support plan in place which was completed soon after they moved in and then after about six weeks to ensure that the appropriate care and support was provided. This included risk assessments in relation to medicines, the environment, moving and handling and any support plans.

Care and support plans contained outcomes that people wanted to achieve. These included maintaining a healthy and balanced diet, opportunities to socialise within the community and maintaining personal cleanliness.

Care workers completed 'home care report books' which covered a whole month and were able to record daily care notes after each visit, meals records, repositioning charts and medicine administration record books. At the back of each booklet was a report book audit which the team leader checked to see if the records had been completed appropriately.

One person using the service told us, "I can go out with my rollator and I go to the charity shop and the cake shop. I always try to let someone know I'm going out – I'd hate not to be able to. If there's no one around, I tell them when I come back." A communal kitchen and two lounges on the ground floor were used to holding events at the service. A coffee morning was held every morning for people using the service which gave an opportunity for them to socialise and get to know each other. A visiting hairdresser was available via appointment.

People using the service told us they knew who to speak with if they had concerns. They said, "Anything that bothered me I'd just tell the carer but nothing bothers me now" and "I'd complain to whoever was in charge – whoever's in the office."

Formal complaints that were received were recorded on paper and electronically on a system called Branch Reporting System (BRS) which was visible to senior managers such as regional managers and directors and the quality assurance team. There was one open complaint at the time of our inspection which was in the process of being investigated by the manager and regional manager. We reviewed the complaints that had been received and resolved since the beginning of the year. We saw evidence the provider acted on complaints received and completed their complaints records with supporting evidence of any investigation reports so there was an audit trail.

Requires Improvement

Is the service well-led?

Our findings

There was a new manager at the service who was applying for the post of registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. After the inspection we received confirmation that the manager had attended, and been successfully registered following her Registered Manager Fit Person Interview.

The providers' values, 'we care, we listen, we strive and we build' were displayed in the main office. A care worker told us, "I enjoy working here, we all try and help and support each other."

The branch reporting system was an effective system for managers to monitor and have an insight into a number of areas used to assess the quality of service this included the number of complaints, safeguarding, incidents and accidents, medicine errors, staff training and supervision and other key indicators.

Incidents and accidents were logged on the Branch Reporting System (BRS) and were investigated and closed by a senior manager after being reviewed. There was evidence that action had bene taken in response to some of the incidents recorded. In one example, a person's risk assessment in relation to handling of COSHH was updated following an incident.

There was evidence the provider was responsive in listening and acting on concerns. For example, we saw where a complaint had been received the provider carried out an investigation and followed up on them. This included speaking with the complainant, reviewing care worker log books, checking rotas and carrying out spot checks and quality assurance visits to people.

The provider submitted statutory notifications to the Care Quality Commission (CQC) for incidents that were notifiable.

A feedback survey was issued to 33 people using the service in July 2017, with a 9% return rate completed by relatives/advocates. The provider produced an action plan based on the survey.

There was evidence that quality assurance checks took place on a regular basis.

Each home care report books was audited by a team leader after it had been completed every month. There was evidence that this audit was effective in highlighting concerns with record keeping, for example, where gaps in MAR charts were picked up the care worker responsible was given extra support and supervision.

Branch visit records were completed following visits from regional managers, members of the quality assurance teams or external professionals from contract monitoring teams. The quality assurance team looked at a sample of care records, staff files and other records related to the management of the service. There was an action plan based on the visit carried out.

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. Issues discussed including housing matters, health and safety, activities and complaints. 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.

A repairs/maintenance book was maintained for any issues that people raised in relation to their flats. It was not always clear from the book if the issues recorded had all been resolved satisfactorily. We spoke to the manager about this who agreed to change the way the maintenance book was completed.

In some cases the monthly report books that care workers completed were not being completed appropriately. For one person, the report book stated the 'my meals record' was to be completed in addition to the daily diary record. However, for the month of September care workers had only completed the daily diary records and not the 'my meals record'.

There was evidence of staff meetings and also evidence of meeting with a representative from the housing association.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not appropriately assess the risks to the health and safety of service users of receiving care or treatment. Regulation 12 (1) and (2) (a)