One Housing Group Limited

Roden Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Roden Court provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is owned or 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. There are 40 flats available for rent. On the day of the inspection there were 37 people receiving personal care.

People's experience of using this service and what we found
People and relatives told us people receiving care from the service and their possessions were not always kept safe. Some people told us they were shouted at and that their belongings had gone missing. Staff were not always aware of what actions to take if they had concerns about people's safety and did not always know how to blow the whistle on poor practice at the service.

People and their relatives were not always comfortable speaking with management about their concerns. Staff were not always confident about speaking out about their experiences. Staff morale was low and team work was poor and an allegation of bullying was made to us.

The provider did not have a robust system to monitor the quality of service delivery as the concerns we found had not been identified and addressed by the provider to drive forward improvements in care. People and their relatives told us the service was ineffective and disorganised and communication with management was poor.

We were not assured by the provider's infection prevention and control measures to minimise the risk of the spread of coronavirus and other infections. The registered manager and staff did not always wear personal protective equipment, such as masks, safely. People's risk assessments had not been updated to reflect the impact of the COVID-19 pandemic on people's needs.

The care records at the service were unclear and disorganised and the provider had not provided enough written information to staff to ensure they knew how to keep people safe from the risks they faced.

The provider's approach to medicine management would benefit from further improvement to ensure they were following best practice. Relative's told us medicines were sometimes missed. Staff who administered medicines were trained and had their competency assessed.

Staff told us there were normally enough staff working to meet people's needs and the rota reflected this. The provider had a system in place to check staff backgrounds before they started working alone at the service.

We found four breaches of the regulations in relation to dignity and respect, safe care and treatment, safeguarding people from abuse and good governance.

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

Rating at last inspection
The last rating for this service was good (published 4 July 2018).

Why we inspected
We received concerns in relation to people's safety and the management of medicines. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Roden Court

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of one inspector on site, a medicines inspector working remotely 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.)

Service and service type
This service provides care [and support] to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought or 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.

Notice of inspection
We announced the inspection on the morning of the inspection to check whether or not there was an outbreak of coronavirus at the service before entering so we could take the appropriate infection prevention and control measures.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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. We used all of this information to plan our inspection.

During the inspection
We spoke with one person who used the service about their experience of the care provided. We spoke with two members of staff including the registered manager.

We reviewed a range of records. This included two people's care records and multiple medication records. We looked at documents in relation to recruitment. A variety of records relating to the management of the service were reviewed.

After the inspection
We spoke with two people and eight family members of people who used the service by telephone. We also spoke with five members of care staff by telephone. We continued to seek clarification from the provider to validate evidence found. We looked at two further care plans and quality assurance records.

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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

● The provider had not set up the service in a way that made people feel safe and protected from abuse. People's relatives told us that some staff were loud and rude to their family members who were afraid of them. One relative said, "I am not comfortable raising complaints or concerns because I am fearful of the repercussions. The relative also stated staff had shouted at their family member, which made them feel frightened. A second relative said, "The staff are rude, disrespectful and don't seem to care… The staff, including management, are unprofessional in their manner. The carers shout in [my family member's] face." A third relative fed back, "[The management's] manner is brusque and off hand and the staff can be rude."

● People's relatives told us their loved ones were still at risk of harm and financial abuse. One relative said, "[My family member] has had money stolen. [My family member] was told to leave [the] door unlocked so carers could get in and [my relative] thinks someone came in in the night." A second relative said, "The doors remain unlocked anyway. This means that people have access to his room." A third relative said, "The staff just barge in. They don't knock."

● During the inspection we observed staff calling to each other loudly and unprofessionally down the corridors between people's flats. Most flats were locked, and care staff had keys to access the rooms to provide care. However, information we held about the service included complaints that people using the service had been issued with a letter asking them to leave their doors unlocked and on the latch and people told us this made them feel unsafe.

The above issues amount to a breach of regulation 10 (dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People living at the service and their relatives did not feel people were safe and protected from abuse. Staff had received safeguarding adults training however, staff we spoke with did not always know how to protect people from abuse. Rather than reporting concerns to the registered manager in line with the provider's policy, two staff members told us they would not report an incident of abuse if their fellow staff member stopped after they told them to.

● Staff did not always know or have the confidence to blow the whistle on poor practice. One staff member said, "I don't know [which external agencies] to report too." A second staff member said, "Some staff may be afraid to speak out [about their concerns at the service]."

● The local authority who commissioned care to be provided by the service had concerns about the the provider's approach and processes to safeguard people from abuse.

The above issues amount to a breach of regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people and their relatives told us that some staff were kind and helpful. One relative said, "The level of care varies. It's ok… The carers seem quite friendly ." The provider had shared the new safeguarding policy with staff at a policy briefing.
●Post the inspection the provider shared with us their customer money and valuables policy; and their customer survey in which three of the four respondents felt the service and grounds were secure.

Assessing risk, safety monitoring and management; Preventing and controlling infection
● The provider did not always protect people from harm by effectively managing risks to people's health and wellbeing. The provider made assessments of people's needs and the risks they faced. Some risks had been adequately planned for such as their mobility needs and risks of stroke but other assessments were inadequate to ensure people were kept safe. A relative told us, "I think there are some aspects of [my relative's] care which are not being met."
● For example, the provider had not updated the infection control risk assessment for a person with a low immune to mitigate for risks involved with the coronavirus pandemic. Further, the risk assessment stated, 'I require staff who support me to maintain effective infection control measures to ensure my immune system isn't compromised.' However, we observed the registered manager enter this person's flat with a fabric mask rather than a face covering meeting the criteria in national guidance. Prior to the registered manager entering the person's flat their fabric mask had repeatedly slipped beneath their nose. This increased the risk of the person contracting COVID-19.
● People who had a history of low mood had not been assessed for an increased risk to their health and wellbeing due to the governmental measures during the pandemic such as national lockdowns. There was no requirement for staff to monitor people's mood and report any concerns they had, putting them at risk that appropriate medical attention would not be sought in cases of poor mental health. The regional manager and registered manager told us that management of this risk was not part of their role.
● People's relatives told us personal protective equipment were not always used safely and staff did not always support people to be clean and hygienic. One relative said, "Gloves are not always worn, and masks incorrectly worn." A second relative said, "[My family member's] bedding is not always changed if [they] had an accident." We observed a second member of staff who was not wearing a face covering in line with national guidelines. This increased the risk of spreading infection.

The above issues amount to a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider supported permanent and bank staff to have weekly COVID-19 tests.

Using medicines safely; Learning lessons when things go wrong
● People were at risk of not always getting the right medicines at the right time. The provider's management of medicines would benefit from improvement to ensure they were following best practice. This has been addressed in the well led section of this report regarding a breach of regulations around good governance.
● Medicine administration records (MAR) showed most people had received their medicines as prescribed, however, we found instances when people had not been given medicines but there was no explanation on the MAR. For example, on one occasion tablets had been signed as administered but had not been given to the person. MAR records were not always accurate.
● The provider used monthly medicine audits to improve the way medicines were handled and identify lessons to be learned from incidents such as discussing errors with staff and providing further training. However, errors still recurred during the following months indicating that the improvements had not been embedded.

Staffing and recruitment

● Rota records showed there were enough staff to meet people's needs and the provider used bank staff to cover gaps due to illness and annual leave.

● Staff told us there were enough staff including for those people who required two members of staff. People and their relatives did not raise staffing levels as an issue of concern.

● The provider had a recruitment system in place to check the suitability of staff, including obtaining references, work history and criminal record checks. Records confirmed this.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was not a positive and open culture at the service. Most staff and people's relatives told us the service was not well run and the registered manager and management team were not accessible. One relative said, "It is very hard to get anything sorted as the management don't respond. Communication is really poor… I understand the difficulties posed by COVID-19 but they weren't effective or efficient before anyway!" A second relative told us, "I think they need to tighten up their service." A third relative fed back, "Some carers are excellent with [my family member's] care. Others just do the minimum required. I feel that their offhand attitude affects [my relative] … Communication with management is often very difficult and I think they just say 'oh, she's in a meeting' to get rid of me… There also seems a lack of communication between management and staff." A fourth relative said, "The whole organisation seems disorganised. The staff and management are rude and there seems to be a lack of communication across the organisation."
- Staff morale was low and some staff members were afraid of raising concerns and speaking out. One staff member said, "Some staff may be afraid of speaking out. For me, there's no problems. We're afraid of losing our jobs. I keep my mouth shut, I don't want to say anything. Everyone has their own issues with the manager." A second staff member fedback that there is a bullying culture within the staff team. It is important for staff to feel confident in speaking out about their experiences and concerns to ensure the service is open and transparent in order to ensure care is safe and effective and people are protected from harm.
- The provider's system to monitor the service was inadequate to ensure care was safe and of good quality. The provider audited medicine administration records to make improvements and had implemented systems to improve the accuracy of medicine support such as discussions with staff and further training. However, the same issues recurred often meaning actions taken had not always improved medicine administration in the following months. The provider's medicine policy followed national guidance but had not been reviewed on time. The registered manager told us this was due to the pressures of the COVID-19 pandemic. Some medicines were temporarily stored on an open shelf in a locked office. It is good practice to keep all medicines in a locked cupboard.
- Shift leaders checked people's care notes after each shift but the management team did not audit them to check the care delivered was what the person needed meaning the registered manager did not have

oversight of people's care putting people at risk of their needs not being met. The provider was in the process of creating new care records for people, however, care records did not include enough information to keep people safe from harm and monitoring systems had not highlighted the shortfalls we found during the inspection. Care files were disorganised, containing loose pieces of paper with people's health care professional's contact details on contained large amounts of information that was no longer relevant to the person involved.

Working in partnership with others; 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; Continuous learning and improving care

● The local authority who commission care for people at the service have concerns about the provider. The records we hold about the service include an allegation that the registered manager behaved in an unprofessional manner at a meeting with health and social care professionals.

● The registered manager did not always lead by example, such as not always wearing personal protective equipment (PPE) safely. When asked about this, the registered manager did not take responsibility for their actions. The regional manager told us they would send an all-staff memo regarding PPE.

The above issues amount to a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care records demonstrated that health and social care professionals were involved in people's care and staff were supported to contact emergency services when required. A relative told us, "In the first lockdown they had to call to GP to change [my family member's] medicines. The staff kept me informed."

● Records showed that people's health and social care appointments were recorded in the main office.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect and their privacy was not always promoted. Regulation 10(1)(2)(a).

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care was not always safe and the provider had not always assessed the risks to people's heath and safety and had not done all that was reasonable to mitigate risks. The provider had not assessed the risk of or prevented or controlled the spread of infections. Regulation 12(1)(2)(a)(b)(h).

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from abuse and improper treatment. Systems were not effective to prevent abuse. Regulation 13(1)(2)(3)(4)(6)(a)(b)(c)(d).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not effective to assess, monitor and improve the quality and safety of the

service or risks to people's health and welfare. Records of care were not accurate. Regulation 17(1)(2)(a)(b)(c)(e)(f).