Independence Homes Limited

Independence Homes Domiciliary Care Agency

Inspection report

2nd Floor, Quadrant House
31-65 Croydon Road
Caterham
Surrey
CR3 6PB

Tel: 01883331777
Website: www.independencehomes.co.uk

Date of inspection visit:
13 March 2019
14 March 2019
18 March 2019

Date of publication:
16 May 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Independence Homes Domiciliary Care Agency (Independence Homes) provides support for adults with epilepsy and other neurological conditions. Some people may also have physical and learning disabilities or mental health needs. At the time of this inspection, the service was providing support within the regulated activity of personal care to 91 people across nine 'supported living' settings. Support ranged from a few hours per day to 24-hour care. CQC does not regulate the premises used for supported living; this inspection only looked at people's personal care and support.

People's experience of using this service:
Whilst there were no significant concerns raised about the services provided at eight of the supported living settings, the people living at Woodland Court were not receiving appropriate care and support. Ongoing failure to address the issues at Woodland Court have therefore impacted on the service as a whole.

The lack of skilled and experienced staff deployed at Woodland Court placed people at risk of harm. Staff were unable to meet people's complex needs and this had a significant impact on people's physical and emotional well-being.

People and their representatives were angry that their views were not being listened to and their experience was further impacted by the low staff morale. Relationships with other health and social care professionals had broken down as practitioners expressed frustration at the lack of coordination of people's care.

Despite receiving continuous feedback about the decline of quality at Woodland Court, the provider had failed to have effective oversight and monitoring of the service.

Rating at last inspection: Outstanding (Published September 2017). The rating has therefore dropped since the last inspection.

Why we inspected: This inspection was carried out in response to multiple concerns that we had received regarding the service being provided at Woodland Court. These concerns were raised by a range of stakeholders and indicated significant issues about the way Woodland Court was being staffed and managed.

Enforcement: Please see the 'action we have told the provider to take' section towards the end of the report.

Follow up: We will be seeking an action plan from the provider and continuing to monitor the service.

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 always safe

Details are in our Safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

Independence Homes Domiciliary Care Agency

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by five inspectors, one of whom was a member of the medicines team.

Service and service type:
Independence Homes Limited provides personal care to people living in one of the service's nine 'supported living' settings. These settings provided a range of small domestic-type houses and larger blocks of flats.

The service did not have a registered manager in post at the time of this inspection.

Notice of inspection:
The inspection was unannounced.

What we did:

As this was a responsive inspection we did not ask the provider to complete a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. Instead, we reviewed the information we already held about the service. This included complaints, safeguarding information and notifications. Notifications are changes, events and incidents that the service must inform us about. In planning our inspection, we also contacted five healthcare professionals who were involved with Woodland

Court in addition to reviewing the information shared by the local authority via the safeguarding process.

On the first inspection day we made an unannounced visit to Woodland Court where we met with people and interviewed staff working at the service.

On the second day we visited the provider's head office where we looked at records including the recruitment information for five new members staff. We spoke with staff members from the centralised human resources and scheduling teams. We also visited Prospect Court where we met with people, staff and the service managers.

On the third day we returned to Woodland Court and completed a review of the way medicines were managed at the service. We carried out observations of medicine practices and reviewed ten medicine administration records. We also met with a representative of the new provider and facilitated discussions between them and people using the service.

As part of the inspection process we spoke individually with 12 of the people who used the service and four of their relatives. We spoke individually with 18 members of staff and joined a managers' meeting where we spoke with the service managers in a group.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

The services provided at Woodland Court were not safe and there was limited assurance about safety. At this setting, there was an increased risk that people could be harmed. At other settings, the consistency of staff and effective internal oversight, minimised the impact of the safety concerns that were identified at Woodland Court.

Staffing and recruitment

● The number and deployment of staff at Woodland Court was inadequate and failed to meet people's basic needs. One person told us, "This place is not good for my well-being" and another said, "My mental health has deteriorated since I moved here." People attributed their decline in well-being to there being insufficient staff and a lack of experienced staff to meet their complex needs. For example, one person described how they needed to regularly use a specialist piece of equipment as part of a rehabilitation programme and that this had not happened. They told us, "They [staff] make excuses about there not being enough staff or experienced staff to help me." The healthcare professionals involved in this person's care informed us that the person's mobility had been significantly and negatively impacted by the failure to provide this support.

● People repeatedly told us they had to wait long periods for support and sometimes they didn't receive the support they needed at all. For example, one person said, "If you ask for something then we are frequently told that they don't have the staff for that. Like last Saturday, I asked for shower support and I never got it." Another person said, "If you need something, then you have to persist in asking for it, otherwise it doesn't happen."

● The instability of staffing levels at Woodland Court had a significant impact on the safety of people's care. For example, one person required specialist treatment at a London hospital and required staff to facilitate these regular appointments. A representative from the hospital informed us the person had missed one appointment and been late for another due to staffing issues at the service. The healthcare professional told us, "These appointments are absolutely vital to maintaining X's health – both in terms of the clinical need and the anxiety caused to X because he knows how crucial the treatment is to him."

● At other locations, service managers were able to mitigate the risk of low staffing levels. For example, one service manager told us, "When the number of people we supported increased, we did not get any extra staff. I repeatedly queried this with Head Office, but just got no response." They went on to say, "We get around it by doing more activities in groups, but it's not right." Likewise, another service manager said, "We should have 11 staff during the day to support people properly, but once or twice a week we will only be allocated nine staff." They went on to say that when that happened, "We re-arrange activities and reduce our management time to keep things safe. We have such a good knowledge of the people here, that we know what we can play around with and what we must not compromise on."

● People did not always get the support they were funded for and staff described how information about people's agreed support packages was not shared with managers at service level. We identified that one person living at Queenhill had received an increase in funding from 1 February 2019, but this had not led to additional staff within the service. This was raised with the new provider, who took immediate steps to

rectify the situation.
●The turnover of staff across the whole service was high. Significant staff vacancies at Woodland Court meant a heavy reliance on agency staff. At Woodland Court people were regularly supported by staff that did not know their needs. One person told us, "Things have gone very downhill recently and there are so many agency staff. I don't like it when people I don't know come in to get me up." Likewise, another person said, "All these different faces come in and it certainly doesn't feel like they have read any of the information about me. If it's not a permanent member of staff supporting me, then I only let them do the basics, because I just don't feel confident that they know what to do." The rotas for the previous four weeks at Woodland Court showed that the service was regularly below the stated minimum staffing levels and that on most days, half the staff working were agency or temporary staff.

The failure to provide sufficient numbers of suitably qualified, skilled and experienced staff was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● New staff continued to be safely recruited. Prior to employment, the centralised Human Resources team obtained details of the applicant's previous work history, two references and a check with the Disclosure & Barring Service (DBS) was completed. The DBS keeps a record of potential staff who would not be appropriate to work in health and social care.

Systems and processes to safeguard people from the risk of abuse
● Whilst safeguarding practices at other locations were being followed, at Woodland Court people were not always protected by the systems in place. In some cases, people had alleged they had been affected by or witnessed abuse. These allegations were still being investigated by the local authority under safeguarding processes and we have shared the information we gathered at the inspection with our partner agencies.
● People told us they felt their needs were neglected. For example, one person said, "The lack of care here amounts to abuse. I feel like a money object and I'm not being treated like a human being." Some people lived in shared flats with people they did not get on with and this had led to safeguarding concerns. As such, one person said, "I don't feel safe here. I don't know who I can trust because whoever I speak with, nothing gets done." Similarly, another person commented, "I hate living with X and being here with them makes me feel unsafe."
● Staff and managers had not always appropriately responded to allegations and reported incidents to the relevant authorities in order to adequately safeguard people. For example, during the inspection people told us about incidents that had occurred at Woodland Court of which staff were aware. On these occasions, correct reporting had not occurred and therefore there had been a delay in concerns being investigated and measures had not been taken swiftly to keep people safe.

The failure to ensure people were protected from abuse was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
•□No concerns about medicines had been raised at other locations. People at Woodland Court however did not always receive their medicines as prescribed. People told us that that their medicines were regularly late, or that staff had brought them the wrong things. Staff reported that there were not always enough trained staff at Woodland Court to manage all the medicines in a timely way.
•□Medicine Administration Records (MARs) were not always accurate. People who managed their own medicines told us that they were not always given a MAR chart to complete. For example, one person said, "I came back from holiday and despite asking, I had to wait two weeks to get a new MAR chart." Likewise, another person informed us, "I've been trained to do my own medicine, but when they don't give me a MAR

chart, I can't follow the training I've been given and that makes me nervous about making a mistake." Where staff had administered medicines, there were gaps in the MARs and staff could not be assured that people had received their medicines as stock balances were not always correct.

•□Staff did not follow the service's own medicines policy. Staff transcribed and made amendments on MARs without records of a second check in line with the policy. The provider could not assure themselves that changes made by staff were under the guidance of the prescriber. Deletions to medicines on the charts could not always be accounted for and some medicines were available to give to people that were not written on the MAR charts.

•□Staff did not always annotate the opening dates of liquid medicines and anticipated expiry dates. On the day of inspection, we found out of date medicines were still in use.

•□Topical creams were not always appropriately stored and were left exposed without lids.

•□Records did not always show why people were given 'when required medicines' by staff.

•□The provider could not evidence that they had processes in place to audit medicines security and administration. However, during our inspection we found that additional staff had been supporting with processes to manage medicines. Their audits had identified 17 medicines related errors. During our inspection we found the errors identified in the audit had not all been resolved. This meant that people were not always receiving their medicines as prescribed.

•□Staff did not undertake ongoing competency checks to ensure they managed medicines safely. Whilst staff completed training on induction to the service and undertook an online refresher course, there was no system in place to regularly observe staff practices unless they had been individually identified as making a medicine error.

Assessing risk, safety monitoring and management

● At Woodland Court, the systems in place to assess and manage risks were not used to ensure people were kept safe. For example, whilst there were fire protocols in place and people had Personal Emergency Evacuation Plans (PEEPs), the staff on duty were not aware of the contents of these. On the morning of the inspection, the fire alarm had sounded and there was no co-ordination of the situation. Some people left the building, whilst others remained in their flats. Staff on duty were unable to tell us who the fire marshals were or what the process was for evacuation. This information was immediately shared with the provider and we have now received written confirmation that fire marshals are identified at the start of every shift and the evacuation process is discussed at the part of each handover.

● At Woodland Court, the risks associated with people's specialist needs were not sufficiently understood and managed safely. For example, it had been agreed with healthcare professionals that one person required twice daily well-being conversations with staff as part of managing their mental health needs. The person told us that this did not routinely happen, and their health was affected as a result. Another person used specialist equipment to manage a known condition and required regular check-ups regarding this. The person told us that staff did not understand the risks associated with this need and their healthcare professional added, "X didn't attend several of their appointments and then we found out they had attended minor injuries because the equipment had not been used correctly and had caused a wound to their skin."

The failure to ensure the safe and proper management medicines and risks was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At other locations, measures were taken to identify and manage risks appropriately. For example, at Prospect Court, the staff team were aware of the risks associated with people's care and took proactive steps to mitigate these.

Learning lessons when things go wrong

● People at Woodland Court were angry that their concerns were not listened to and when they raised issues, they were not addressed. This resulted in a cycle of the same issues. For example, one person told us, "It's like Groundhog Day here, the same things go wrong over and over again, and nothing ever changes."

● Relatives at Woodland Court expressed the same frustrations, with one relative explaining, "We just seem to keep going around in circles. We raise issues, have meetings where we are told it will get better and then the same things happen again." Another family member advised, "We've tried to be reasonable and work with them, but it's always the same – constantly over-promised and under-delivered."

● Staff were equally concerned about the lack of learning from complaints and incidents. Staff across all locations repeatedly described a culture of blame rather than improvement.

● Despite confirming they were aware of the concerns raised in this report, the senior management team, including the former Nominated Individual failed to provide assurances that lessons had been learned.

Preventing and controlling infection

● There continued to be appropriate systems in place to manage infection control.

● House-keeping staff were observed to be working across locations to maintain standards of cleanliness.

Requires Improvement

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations have not have been met. The service did not have a registered manager in post.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People at Woodland Court felt their opinions did not matter and told us that their views were ignored. People described situations where things had gone wrong and reasons why they were unhappy and each time we asked whether they had raised complaints we were told, "You might as well talk to a brick wall as nothing gets done." Another person said, "It feels like they are exploiting our neurological conditions – you know, in hoping we will forget."
● People and other stakeholders repeatedly told us that they had raised concerns and issues at 'Every level', but the result was the same – that nothing changed.
●The provider was not recording or acting upon people's concerns. A review of the complaints log for the whole service highlighted that not all complaints were being documented. For example, complaints that we knew had been passed to the provider to investigate had not been included on the log. A relative told us, "I had a couple of calls with [provider name], but I was just fobbed off and found them to be very rude." Their complaint had not been recorded on the log. Similarly, a person told us that their repeated complaints to staff had resulted in the provider meeting with them in January 2019. They went on to say. "I told them exactly what was going on here and why it wasn't good, and they told me they would get it sorted. Nothing changed as a result." Again, this complaint was not recorded on the complaints log.
● Despite opportunities to work collaboratively with other professionals to deliver appropriate support at Woodland Court, key relationships with other health and social care professionals had broken down. For example, one practitioner told us that they had previously worked well with some key staff employed by the provider, but that when those staff left, so did the partnership work.

Planning and promoting person-centred, high-quality care and support; Continuous learning and improving care
● People at Woodland Court told us that they felt the focus of the service was on making money and not looking after them. For example, one person told us, "I might have a nice flat, but I have no care. Why did they bring me here if they don't want to look after me?"
● Staff told us during a meeting that they felt the focus from senior management had been on maintaining an outstanding rating, rather than delivering outstanding care.
● Whilst multiple stakeholder complaints, tenants' meetings, audits and quality checks continuously raised issues to senior managers about the problems at Woodland Court, actions had not been effective in bringing about change.

The failure to improve the quality and safety of the services provided was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; how the provider understands and acts on duty of candour responsibility

● There was a lack of leadership of Woodland Court in which there was no ownership for improving quality. Relationships between staff and management had broken down and there was a lack of clarity about who was responsible for driving improvement. Staff at service level reported feeling disempowered by senior managers and told us, "We are given no authority, but all of the blame." People were caught in the middle of an increasingly negative culture. For example, one person told us, "Now everyone is frustrated, and we are all behaving in ways we don't want to as a result."
● Whilst some additional resources had been allocated to the service in respect of addressing areas such as medicines, there was no oversight of what was being done at a service level to monitor that these were being effective and whether anything more was required. Where the provider had made promises to people that issues would be addressed, there had been no follow-up to ensure this had happened.
●We requested an improvement plan from the provider who assured us that action was being taken to address the concerns that were being raised. As part of that improvement plan, we were told that a dedicated e-mail address had been set up for staff to be able to raise concerns directly with the provider. Despite this, concerns, complaints and whistleblowing allegations have continued to be raised with ourselves from all stakeholders who stated that their concerns about staffing levels, skill sets, and medication were still not being listened to and addressed.
● We identified that statutory notifications had not always been submitted. In addition to the previously mentioned allegations of abuse that had not been reported, the service had also failed to notify us of the staffing issues which were impacting on the delivery of the regulated activity.

The failure to notify the Commission of reportable incidents was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Following the inspection we had a meeting with the provider and assurances were given about the actions being taken to make the necessary improvements at Woodland Court. We have been told that significant additional resources have been allocated to Woodland Court in order to stabilise the staff team, develop skills and ensure effective oversight. The provider has agreed to share progress openly with ourselves and we will continue to monitor that this happens.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to ensure that the Commission was always notified of reportable incidents without delay.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure the safe and proper management of medicines and risks.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure the systems in place appropriately safeguarded people from the risk of abuse.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have proper oversight of the service and had failed to implement systems that ensured the ongoing improvement of quality and safety.

Regulated activity	Regulation

Personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had failed to provide sufficient numbers of suitably qualified, skilled and experienced staff to safely and appropriately meet the needs of people who used the service.