Comfort Call Limited

Comfort Call (Liverpool- Latham Court)

Inspection report

Latham Court
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 6, 7 and 17 October 2016 and was announced.

The service was an Extra Care Living Scheme. A housing association held the tenancy agreements with the people who lived there, some of whom were being provided with care by Comfort Call Limited. At the time of our inspection there were 33 people receiving care packages from the service. There was one staff member present at night time and a Tunstall Alarm system in place for people to raise the alarm if they needed emergency assistance.

There was a registered manager in place at the time of the inspection however, we were concerned they did not have oversight of the service. Another registered manager was in attendance on the inspection. 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.

The service was managed day to day by a Scheme Manager who was responsible for undertaking supervisions with staff, overseeing the care delivery and reporting to the registered manager and Area Manager. We found that the registered manager and scheme manager, who were relatively new to Latham Court, did not know the people who were receiving care well and relied upon staff for information about them.

We were informed by the provider that they had no choice over who they provided care for and decisions were made as to who required care without consultation with Comfort Call Limited. We were also informed by the provider that they were only provided with basic information about people who they were asked to deliver care to. This meant the assessment process for people being accepted into the extra care living scheme at Latham Court was not robust. We were informed by the provider there were no people with complex care needs living at Latham Court. However, we found during our inspection the staff were delivering care to people with complex care needs. We were therefore concerned that the care provider did not have a full oversight of the dependency levels and complex needs of some of the people who lived at Latham Court.

We found staff were able to describe different types of abuse and what they would do to report alleged abuse but we found the system in place to safeguard people who lived there and associated documentation were not robust. The documentation did not provide a detailed account of the events of an incident and staff were not reporting all incidents/safeguarding concerns in a timely manner. We highlighted this to the service who then put a new handover sheet in place for staff to relay any concerns. However, when we returned to check the effectiveness of the new handover sheet we found that people were still not being safeguarded in a timely manner or with a detailed record of events.

The Mental Capacity Act 2005 legislation had not been implemented within the day to day delivery of care for people. It was unclear from the care plans if people had mental capacity to make all decisions or some decisions as there were no details about which decisions were difficult for the person and no record of a named person who was best to consult with as part of a best interest's process. Staff who wrote care plans and risk assessments were not knowledgeable about decision specific mental capacity questions. The service acknowledged this and had planned Mental Capacity Act training for all staff to be completed by the end of November 2016.

Care plans did not provide enough detail about people for staff to know what their background was or their likes or dislikes to be able to support them effectively. There were no care call times specified in the plan of care or evidence family members/next of kin were being consulted in the process of writing the care plan. People didn't always have a choice of male/female carers.

Risks were not being managed effectively with some risk assessments not being updated when needed or in some instances there were no risk assessment at all for staff to follow. Incidents were not always being recorded and staff were not always acting in people's best interests. The daily records did not include whether a person had the mental capacity at the time of declining care or food with poor recording of information.

Staffing levels were not sufficient to allow time for staff to always provide care for the duration of the call times specified in the Local Authority support plan. We viewed in the daily records carers were leaving a person's home earlier than they were required to provide care according to the Local Authority support plan. There was no documentary evidence why the call time was shorter than specified on the rota. Therefore, some people were not receiving the amount of care hours as stated on their Local Authority Support Plan agreed on admission. We were also made aware of this by the Local Authority who had raised this issue with the care provider.

Recruitment systems were in place however, not all staff were being provided with an induction to ensure all staff including staff who have been transferred from another care provider received an induction. The registered manager agreed to address this. Staff training was extensive however we were concerned staff were not always implementing and consolidating it. For example, staff had received training in Safeguarding however we found staff were not always documenting safeguarding concerns effectively or safeguarding people in a timely manner.

There were safe systems in place for administration of medication including a medication risk assessment seen in the care plans.

Information regarding how staff were to support people with nutritional needs was not detailed enough and people who were declining to eat were not always being supported effectively. For example, we found one person who had declined to eat over a period of time had not been referred to health care professionals or the Local Authority with concerns regards self-neglect.

People told us they were not always being supported to access the healthcare they needed to access such as the Dentist and Opticians. We received information from social care and health care professionals raising concerns some people were not receiving effective support or support for the duration of time needed. One healthcare professional told us that staff were not always supporting people as requested by the healthcare professionals and in one instance a person was admitted to hospital due to this. However, one healthcare professional also told us they had no concerns regarding the care being provided.

The service was not caring. People's dignity was not always being upheld when staff spoke with them and people with complex family backgrounds with no next of kin were not being referred for advocacy services.

Staff were not being provided with enough detailed information in the care plans for them to know how to encourage people to be as independent as possible.

We viewed the quality assurance forms completed with people which were not tailored to the communication needs of some people with learning difficulties. Therefore, we did not consider that the service were doing all that was possible to obtain the views of all the people who were receiving care in the best way to meet their needs.

The service was not being well-led as the system failures identified during the inspection had not been identified through the audit systems and quality control systems in place.

The overall rating for this service is inadequate and the service is therefore in special measures.

The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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.

Staff were not always taking action to report abuse in a timely manner.

Risks were not always being assessed, reviewed, documented clearly or acted upon in a timely manner.

Incidents were not always being documented with appropriate action taken.

There were not enough staff to provide care for the duration of the care calls.

Is the service effective?

Inadequate

The service was not effective.

Staff were not knowledgeable in the Mental Capacity Act 2005 and were not documenting detailed information regarding people's mental capacity when they were refusing/declining food or care.

Staff training was not always effective with competency checks. Although staff had received safeguarding training they did not always identify self-neglect as a Safeguarding concern reportable to the Local Authority.

People were not always supported in accessing healthcare when they felt they needed it.

Is the service caring?

Inadequate

The service was not caring.

Staff did not always speak to people in a respectful manner.

People were not being encouraged to be as independent as possible with aspirations documented.

Advocacy services were not being sought for people.

Is the service responsive?

Inadequate

The service was not responsive.

People and their family members/next of kin were not involved in the assessment of the plan of their care.

Care plans were not always reviewed when changes occurred and did not provide accurate detailed information about people for staff to be able to provide person centred care.

The systems in place for people to make their views known were not person centred enough to meet their needs including people who had learning difficulties.

There was a system for dealing with complaints.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager in attendance for the inspection and Scheme Manager did not have up to date knowledge of the people who lived there.

The system failures identified on inspection had not been identified through the quality assurance auditing systems in place which demonstrated a lack of effective governance.

The care records were not robust with a lack of detailed information to capture information when an incident had occurred or when there were safeguarding concerns. A failure to contact emergency services and to safeguard in a timely way had not been identified through the quality assurance checks in place.

Comfort Call (Liverpool- Latham Court)

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.

The inspection took place on 6, 7 and 17 October 2016 and it was announced. The provider was given 48 hours' notice because the location provides an extra care service and we needed to be sure that someone would be in.

The inspection team consisted of one Adult Social Care Inspector.

A Provider Information Response (PIR) was completed and sent to us on 5 June 2015. This is a form which requests specific information from providers which informs us about the service prior to our inspection. Prior to the inspection we also viewed the information held by the Commission including the statutory notifications we received from them.

We viewed six care plans, four staff files, spoke with five people who use the service and 12 staff which included the additional team of staff members brought in during the inspection.

We spoke with one relative, contacted three healthcare professionals and liaised with the Safeguarding Authority and Commissioners as part of this inspection.

Inadequate

Is the service safe?

Our findings

We looked into how people who use the service were being protected from abuse. We spoke with one staff member who told us they would report abuse straight away and they were aware of the different types of abuse. Another staff member was able to explain who they would report concerns to and were also aware of whistleblowing. However, we found staff were not always reporting abuse to the Safeguarding Authority or the Police in a timely manner.

One person who was at risk of abuse was not referred by the service to the Safeguarding Authority until we requested that they send a safeguarding referral. This was then actioned six days later. Although the service had contacted the person's key worker in the local authority they had not followed this up with a safeguarding referral. We were assured by the service they would improve their system and we made further checks to see if improvements had been made. We found a new handover sheet had been implemented. However, we found that the information being documented was not detailed enough and action had not been taken as soon as staff became aware a person was at risk of abuse. We viewed the handover sheet which highlighted the person was at risk of further abuse. The service alerted the Safeguarding Authority two days after they first became aware of the alleged abuse. We remained concerned the system in place of reporting abuse was not robust enough and concerns were not acted on in a timely manner in order to protect people.

People who were neglecting themselves by declining care were not being referred to the local authority by the service. We checked one person's care plan and daily records which stated they had declined food at different times of the day for a number of days and also declined to receive care however, the service had not identified this as self-neglect or reported it to the local authority. Another person who's mental capacity was impaired and had a history of self-neglect had not been referred to the local authority by the service. We received information from a health care professional who raised concerns staff were not documenting enough when a person neglected themselves for the healthcare professional to be fully informed. We were concerned staff were not identifying self-neglect as a safeguarding concern reportable to the Local Authority and the system in place for reporting and recording self-neglect was not robust.

The service took action and provided us with a copy of a memo provided for all staff to set out what they were required to do to safeguard people. This new system involved staff completing a handover form which identified the following areas for staff to be vigilant of, "Neglect, fluctuating capacity, physical abuse, financial abuse" and to hand over the form to the manager at the end of the shift. We found when we returned on the third day of our inspection that although staff had written some information on the new handover sheet, it was not detailed enough and staff had not reported a person was at risk to the local authority or the Police until two days after they became aware of it. This meant that the new system of protecting people from abuse was not robust and needed further improvement.

This was a breach of Regulation 13 of the Health and Social Care Act Regulations 2014.

We checked five staff files and found they all contained a Disclosure Barring Service check (DBS). This is a

checking system to ensure previous criminal convictions are highlighted prior to staff working with people who require care. We found one staff file did not contain evidence of an interview being undertaken.

We looked into the system of recording, reporting and acting when an incident or accident occurs to ensure systems in place were robust. This involved checking the incidents and accidents logs with accident forms and information written in the communication book by staff. We found not all incidents written in the communication book were being recorded as an incident to provide a contemporaneous record. Staff were not taking appropriate action to protect people from harm. For example, the communication book in the staff room stated one person had impacted their head during a fall but there was no incident report form. We were informed by a staff member this was due to them not having incident forms filed in the staff room at the time for staff to complete it. However, despite this incident taking place some weeks prior to the inspection the staff member had still not completed an incident form. The staff member wrote in the communication book they assisted the person back to bed as they refused for an ambulance to be called. We discussed this with the registered manager who told us they would have expected the staff member to phone for an ambulance and ensure a medical/health assessment had been actioned for the person as they may have been suffering with confusion/concussion. We further case tracked the person which involved looking into additional records and found they had a history of falls. Despite the person having a fall in May 2016 and September 2016 the falls risk assessment had not been updated since 10 October 2015. The registered manager informed us care plans are reviewed annually unless there is a change. We were concerned the falls section of the care plan had not been updated following a change of further falls.

We looked into how the service managed risks for people and found risks were not always being identified, assessed or reviewed with appropriate action. Out of the six care plans we looked at we found risks had not been identified, assessed or reviewed in five of the care plans we viewed. The care plan with no issues concerning risk was a care plan for a person who needed a low level amount of care. One person who was distressed and expressing suicidal ideas returned to their home with assistance from the police during the inspection. Despite the police informing the service that the person expressed suicidal ideas the service did not escalate seeking a medical assessment urgently or ensure a staff member was present with them to provide support.

We visited another person in their home who was receiving care. We spoke with them regarding their care and how they viewed the cleanliness of their home. The person was able to tell us that the reason their bathroom was not in a hygienic state was due to the problem of them vomiting regularly. We were informed by staff that the person had declined for staff to clean their home on several occasions and so the condition of the flat was an infection control risk with bodily fluids including what the person told us was vomit over their toilet and sink. Staff members were planning to clean the person's home with the person's consent that day. We spoke to one of the staff members who had been requested to clean the person's flat who had not been asked to do this previously and they were unaware it was in an unkempt state posing an infection control risk. They informed us they were cleaning the flat with a second staff member who were more experienced however there was no risk assessment in place in the person's care plan for staff to follow.

The service was providing care in an extra care scheme whereby the people receiving care had tenancy agreements with a housing company. Despite the service not being responsible for the accommodation for people receiving care, they were working collaboratively with the housing officer and had a duty of care to report any risks they identified. During the inspection we became aware that not all smoke alarms were working. We visited a person with their consent who was a heavy smoker. During our visit the person was smoking with their lounge door wide open. We observed the person had a smoking blanket on their sofa to protect them whilst smoking but the smoke alarm was not activated. We spoke with the person about this who's capacity was impaired. They told us that they didn't think it was working but didn't consider this to be

a problem. This was reported to the manager and senior carer who told us they were aware some smoke alarms had been deactivated as they were due to be upgraded. We asked the service to raise this as a fire risk with the housing officer and request that they be turned back on and activated immediately.

We viewed one care plan which provided conflicting information regarding the risks posed for the person receiving care. It was not clear from the information documented in the care plan what staff were advised to do. This placed the person at unnecessary risk of potential harm. Another person's care plan did not contain all of their health diagnoses for staff to be fully aware of health risks.

This is a Breach of Regulation 12 Safe Care and Treatment Health Care Regulations 2014.

We spoke with people who use the service and looked into how the systems in place were working to keep people safe. One person said, "I feel totally safe here", another person told us, "Yes I feel safe".

We checked if there were enough staff to provide care to meet people's care needs. One person we spoke with told us – "staff rush in and rush out, don't have time for a chat". Another person we spoke with told us staff didn't always stay for the duration of the call.

We were informed by the registered manager there were previously two staff members on at night time but this had reduced down to one staff member as two were found to not be required at night.

We checked one person's local authority assessment which specified the duration of the care calls needed. We viewed the person's daily records and found that staff recorded when they entered and left the person's home detailing the amount of time they had spent with the person on the care call was not always for the duration of time assessed as needed. There was no explanation documented by staff why the call was not for the duration therefore, we could not be sure staff ended the care call at the request of the person. For example, the morning call specified by the local authority assessment was for one hour for one person. We viewed in the daily records and found staff had provided minutes care in the morning on one occasion, 15 minutes care had been provided on another occasion when the call time specified by the Local Authority was 30 minutes. We viewed another person's daily records and local authority assessment which specified the person needed 30 minutes care in the morning and evening. We found they were not always receiving care for the duration of the care calls. For example, they had received 10 minutes care on one occasion and 15 minutes care on another occasion with no explanation documented as to the reason why.

We viewed the minutes of the August 2016 Monthly Board Meeting which stated "rotas at present are overlapping with clashing calls which is compromising the safety of the service. There is more care being provided than staffing levels. Fortunately, there have been no missed visits however it is becoming hard to maintain and provide quality service which also is adding to the number of CQC safeguarding notifications. A template rota system has been drawn up and extra runs developed. A new run on the rota has been authorised to help elevate pressure on the existing staff". This means an extra run was devised on the rota to ensure calls were not needed at the same time and did not clash. However, this would not reduce pressure on staff as the actions taken by the service according to the report did not include a review of staffing numbers in relation to the dependency levels and the care needs of the people needing the care.

We also received information from the Local Authority one person had not received the level of care and support contracted for when they began living at Latham Court. We were advised that a process of recruitment was underway by the care provider to meet their contractural responsibilities, to provide adequate staffing levels to be able to meet the needs of the person.

Inadequate

Is the service effective?

Our findings

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 supported 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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We viewed six care plans and found each service user had signed a service user agreement when the person first began to receive a service. We did not see evidence that written consent had been sought from service users to agree to the plan of their care including times of their calls being delivered by Latham Court. We viewed a signed service agreement but this did not detail the plan of care. This meant service users were not being included in the decision making process in respect of their plan of care including the times of their calls and consent being sought. Consent to receive support with prescribed medication was seen in care plans we viewed however, people who had fluctuating capacity or capacity issues did not have decision specific mental capacity assessments in place to demonstrate the care provider had obtained lawful consent.

One care plan we viewed dated 30 May 2016 stated, "I am not able to answer the door and access arrangements are: staff let themselves in". It also stated Key holders were, "Carers". It was not documented if the person's consent had been obtained for carers to act as key holders. During the inspection the person's mental capacity was observed to have altered, deeming them to have fluctuating capacity. At the point when the person's mental capacity fluctuated, the service revised the care plan to include what staff needed to consider when the person's mental capacity fluctuated again in the future and stated - "X can make some decisions but their capacity can be significantly diminished". However, despite the care plan being updated there were no decision specific assessments or evidence that best interests decisions had been undertaken by the service.

We viewed another person's care plan and found it stated the key holders were staff at Latham Court however, there was no evidence the person had provided their consent for staff to hold a key. It stated in the "Making decisions/best interests section" of the care plan - "X is not good at making decisions". However, the service had not identified which decisions were difficult for the person to make. There were no mental capacity assessments or best interest's decisions in place. Upon meeting with the person during the inspection we found the person had some difficulties comprehending and processing information which led to concerns about their mental capacity to make some decisions.

We viewed daily records and found staff were not documenting information regarding whether a person was deemed to have mental capacity when they declined an aspect of their care such as food. This information

is essential for health care and social care professionals to be able to assess a person's mental capacity and decision making over time.

We checked the mental capacity policy first published July 2015 and for review June 2016 written by the service which stated -"Care plans will state whether the service user may have issues with mental capacity and, if so: detail the basis of that belief, indicate where possible, the kind of decisions that the service user may or may not be able to take at most times, identify any individuals who should be consulted in respect of determining whether a particular decision would be in the service user's best interests". We found that the service was entering into the care plan at the time it was written if the person had difficulty making decisions. They were not then following the policy requesting that they detail which decisions were difficult and who needs to be consulted as part of a best interests decision.

This is a breach of Regulation 11 of the Health and Social Care Act Regulations 2014.

We spoke with health care and social care professionals during our inspection to find out what their views were about the care being provided for people. One healthcare professional we spoke with told us they had no concerns about the care provided. Another healthcare professional told us that one person who suffered with a condition requiring prescribed medication including prescribed creams had not been supported by the staff to apply their creams and as a consequence they were admitted to hospital with an infection and a safeguarding referral was sent to the local authority. Another person who had a condition and required regular medication had not been supported to take their medication.

We looked at whether staff were knowledgeable and had the appropriate support to be able to provide effective care. Two out of the five staff files we viewed did not contain an induction when the staff member started working for the service. This meant the staff had not received all the information including policies and procedures of the service when they began providing care for people. We asked the manager about this and they told us this was due to the two staff members being TUPE (Transfer of Undertakings Protection of Employment) transferred across from another service. This was discussed with the manager who agreed all staff are required to have an induction to ensure they are aware of the company policies and procedures.

We checked the training provided for staff to ensure they had the skills and knowledge to care for people effectively. We spoke with the trainer and asked for confirmation of their training qualifications to ensure they were skilled and up to date to provide training. The registered manager told us the two main areas they were focusing on with staff was mental capacity and medication. The manager confirmed the service was providing Mental Capacity Act training for all staff, which was to be completed by the end of November 2016.

We found the training being provided for staff included Health and Safety, food safety, infection control, First Aid, medication, assisting in moving and handling, safeguarding, end of life care, stroke awareness, Parkinson's disease, diabetes, privacy and dignity and dementia. Some staff training records also evidenced they had received training in Enteral Feeding.

The registered manager provided us with examples of hand held size reminder cards with details for staff regarding safeguarding and the Mental Capacity Act 2005. There were informative posters on display in the staff rooms and the office regarding different topics such as infection control, safeguarding and mental capacity.

Despite staff having training in safeguarding and the service displaying information regarding safeguarding we were concerned staff did not identify self-neglect as a safeguarding concern reportable to the Local Authority, which demonstrated a lack of understanding. The Commission therefore, placed no confidence

that the provider was ensuring theory had been put into practice to ensure staff were competent to carry out their roles safely and effectively. It was clearly documented on the "Support to Safeguard" pocket sized reminder for staff about Safeguarding that self- neglect was a sign of abuse for staff to be alerted to. The information for staff stated Self Neglect included – "poor hygiene, nutritional intake or weight loss, dehydration and withdrawal from society."

We spoke with staff to find out how much they understood about the Mental Capacity Act and found one staff member had never heard of decision specific mental capacity assessments. Another staff member told us mental capacity is about the person making their own decisions but did not have any further knowledge. We were concerned staff had a lack of understanding regarding mental capacity which was impacting on the quality of the care being provided for people. For example, staff were not always following the best interests process. One person who had fallen whose head was described as stuck between the sink and the radiator who then declined medical attention was assisted back to bed by a staff member. The staff member placed the person at unnecessary risk of harm by not following the best interests' process and calling emergency services or for a medical assessment.

We looked into if people were having enough to eat and drink. Most people we spoke with told us they were being supported to prepare food and meals. One person who needed a PEG (Percutaneous Endoscopic Gastrostomy) told us they were able to eat small amounts of food during the day and they had a PEG feed at night. The person also told us they suffered with vomiting. We checked the care plan and there were no details for staff to follow to inform staff how to best support the person with their food intake in the daytime and how to assist if the person suffered with vomiting. There were no details including which foods/drinks the person liked or was advised by their Dietician to eat/drink. We were aware a Dietician was involved in the person's care but there were no details or a prescription for staff to follow clearly documented in the care plan. We found another person who had been repeatedly declining food but there were no details in their care plan to inform staff of foods to encourage the person to eat or mention of consideration of a referral to a Dietician.

This is a Breach of Regulation 14 Nutrition and Hydration of the Health and Social Care Act Regulations 2014.

We found healthcare professionals were visiting people at Latham Court to provide them with healthcare service such as District Nursing services and Dietetics services. However, one person we spoke with told us they had repeatedly asked the staff to assist them to visit the dentist and opticians as their glasses prescription no longer improved their vision and they had visual problems. We asked the manager to look into this during the inspection.

Inadequate

Is the service caring?

Our findings

We found the service did not always consider the needs of people in a caring way and staff did not always speak to service users in an empathetic, respectful or caring manner. We observed a staff member speaking to one person in a warm and empathetic way. Another staff member then entered the room and did not address them by their name. The staff member began commenting on their behaviour which led to the person withdrawing with their head down looking at the floor as though they had been told off and treated like a child. This was at a time when the person was distressed in need of empathy, support and reassurance. We spoke with the manager who was also present when this occurred. The manager agreed to speak to the staff member about the way they interacted with the person and the impact it had. However, the same staff member had been provided with the responsibility of supporting the person later that day during a General Practitioner (GP) assessment. We were concerned that the same staff member who had been disrespectful to the person that day had been provided with more responsibility to be in the person's company later on in the evening despite this being highlighted and discussed with the scheme manger and registered manager.

One person's care plan which stated they found making decisions difficult and did not have a next of kin or emergency contacts had not been referred for advocacy services by the service. We asked the registered manager for any examples when the service had researched or sought advocacy services locally but we were not provided with any information to reassure us the service were aware what was available in the local area for people. We found the service was not following their policy regarding advocacy services for people. We checked the policy on 'person centred care', first published in April 2016 which stated -"Service users must have access to all the information and advice they need to make informed decisions, including advocacy services". This was a concern as the care plans for two people who we met during the inspection had mental capacity issues with no family support in making decisions and therefore needed advocacy.

We were concerned the service was not considering how to maintain people's dignity. We spoke with one person who was a proud person who did not wish to receive assistance for personal care from a male carer. We found the service only offered a male carer from 8pm to 8am the next day. Therefore, the service had not considered that for people who were not comfortable being supported by a male carer their dignity was being upheld. We discussed this with the registered manager who told us they previously offered a male and female carer and this could be addressed again in the future. The person told us their evening call to assist them to prepare for bed was too early and they preferred to retire for bed as late as 10.30pm – 11pm. The person said that the reason the care call was early was due to them not wishing to have support from a male carer to undress them. As there was only a male carer available in the evenings and they preferred a female carer they were agreeing to be supported as early as 7pm to change into nightclothes ready for bed. We discussed this with the registered manager and the scheme manager who said as the person was choosing to receive care by a female earlier in the evening they were providing person centred care. We discussed this further and disagreed they were not providing male/female choice of carers in the evenings and therefore, not providing choice or person centred care and respecting the wishes of the person.

The impact of not providing a choice of male/female carers was that in the event someone was opposed to

receiving care by a male or female carer for personal care, it could lead to disengagement or disempowerment affecting the emotional/psychological well-being of the person needing care. The person told us they declined to see members of their family in the evenings as they did not wish to have visitors whilst sitting in their nightclothes. This was therefore, precluding the person's freedom of choice, autonomy and created social and family isolation.

The service was an Extra Care Living Scheme to provide care in people's homes but to encourage as much independence as possible. We looked into whether people were being encouraged to be independent and found people's aspirations/goals were not being documented for staff to be aware what people wished to achieve. One person whose mental capacity was impaired did not have any information for staff to follow to encourage their independence or any strategies to try to encourage the person in everyday activities. The care being provided was task led with staff providing task based care with no information what to encourage the person to achieve to maintain their independence and well-being.

This is a Breach of Regulation 10 Dignity and Respect of the Health and Social Care Act Regulations 2014.

One person told us, "They're all very good", when we asked if staff were caring. Another person said - "The girls are lovely, they're really helpful". One staff member we observed spoke with one person in a respectful and helpful way when explaining information to them.

Inadequate

Is the service responsive?

Our findings

We checked to see if people were being involved in their plan of care and if they contributed to their own assessment of care needs. The care plan is an important document for staff to follow to help to ensure they know how to care for someone effectively. Staff who do not know the person rely on an accurate, comprehensive care plan to provide them with the information they need to know how to care for the person in a person centred way.

We looked at six care plans none of which specified the times of the calls when people needed their care or for how long. This is important information for staff to know exactly when people would like their care and to ensure they are included in the decisions about when staff arrive at their homes to deliver care. The care plan stated if a care call was needed in the morning, lunch time, tea time or evening but there were no specific times documented in the plan of care. The care provider agreed to provide people with a copy of their rota during the inspection.

In an Extra Care Living Scheme were people are to be encouraged to maintain their independence and to have activities of interest to motivate them to undertake as much for themselves as possible, we were concerned the care plans we viewed did not contain detailed information to inform staff what people's preferences, interests, likes and dislikes were for staff to be aware of. There was no information in relation to what the person liked to do or if they had been asked about what they liked to do to occupy themselves as part of the assessment. We were concerned the assessment had not been comprehensive enough and did not provide accurate information at times. For example, the communication section of the care plan stated – "X has no problems", but then states staff can assist me by – "talking slowly". Therefore, it was unclear what the person's communication difficulties were. Upon meeting the person we found that they could only manage short amounts of information at any one time and had difficulty providing eye contact. The life story section of the person's care plan stated - " I like to do things independently, very quiet and now has a PEG feed 10 hours, 9pm to 7am." There were no details about the person's background for staff to know important things about the person for them to then be able to engage with them to build a rapport in a person centred way.

Another person's care plan was not providing an accurate assessment of the person and stated – "X likes to stay in the flat watching TV". We spoke with the person who told us they did not like spending all the time in the flat and needed company of others. They told us they enjoyed talking with people and didn't feel going to bingo once every week was enough contact with people. We were concerned the person was isolated and lonely requesting more contact with people, however, the care plan led staff to believe they enjoyed being in their flat watching TV. Therefore, staff reading the care plan would not be vigilant to the risks of the person becoming socially isolated.

Another care plan dated 1 March 2016 had not been updated when changes occurred despite changes occurring in relation to risks due to self-neglect and their mental capacity. The person's care plan did not have the correct up to date information including the current assigned social worker with their contact details despite staff being aware there had been a change to the assigned social worker. This was

particularly important as the person did not have any emergency contacts or next of kin as contacts.

This is a Breach of Regulation 9 of the Health and Social Care Act Regulations 2014.

We checked to see what systems were in place where the service sought the views of the people who received care and if people were being listened to. It is important for people to have opportunities to make their views known and to communicate what they feel needs to change regarding their care. We viewed the Quality Assurance Visit Record sheet which is a form used by a staff member visiting a person receiving care to ask them set questions and record the person's views. This is a visit for staff to check the correct documentation was in place in the person's home and other questions such as if carers arrived on time and if carers remained for the full time needed. One quality assurance form dated 13 July 2016 stated that the person's view was -"Some care workers don't encourage me or ask what I need". There were no actions taken following this or evidence this was then looked into for the person. Another Quality Assurance Visit Form which had been completed with a person who had communication difficulties was not adapted in a person centred way which addressed their difficulties with communication. Therefore, we were concerned that the questions being asked were not being put in a way they would understand. Therefore, we were not assured the service were doing all that could be done to listen to people's views.

The activities offered to people at Latham Court included bingo once per week which was being organised by a relative and a bacon sandwich club once per week where people could meet and raise any issues they had with the Scheme Manager or Housing Officer. Two people we spoke with told us they did not find the meeting helpful and they did not attend. Others told us they did attend and found it useful as they could raise any issues regarding their housing needs. The Scheme Manager told us the service were trying to offer what people needed and they were in the process of putting a case forward for a workshop to be built for one person who has an interest in this.

We viewed the complaints file and viewed a system in place for dealing with complaints. The file contained complaints which the scheme manager was dealing with and not the registered manager. One complaint we viewed included concerns from a social worker that a person had not been receiving the level of support they should have been receiving. There was evidence of the Scheme Manager dealing with this and setting up a meeting to discuss it further. We were informed by the registered manager all complaints were closed off by the Regional Manager.

Inadequate

Is the service well-led?

Our findings

The system failures which had been identified as part of the inspection had not been identified through the quality assurance checks, audits and management of the service.

We viewed the documentation in the communication book in the staff room completed by day staff and night staff. It was documented that an incident had occurred but when we checked the incident file there was no incident form. This had not been identified through the quality assurance checks within the service.

We looked into the governance around safeguarding, incidents and risk. The Branch Managers meeting minutes dated 7 June 2016 stated – "All Safeguarding referrals/incidents must be referred to CQC. Even if you think that it is minor – notify it. This is a legal requirement. Regional Managers will be checking the compliance of this at each visit and at the monthly review." We were concerned the actions documented regarding this had not mentioned checking staff had also made a referral to the Local Authority when appropriate. Despite this action being documented within the quality assurance meeting minutes, we found failings in reporting incidents and safeguarding concerns. Therefore, the governance and quality assurance systems in place were not robust enough.

At the time of our inspection it was unclear which registered manager had responsibility for the oversight of Latham Court. A registered manager in attendance on the inspection along with a Scheme Manager who had day to day management responsibilities. We asked how the service was being managed by the registered manager as the staff we spoke with had not met the registered manager and service users we spoke with had not heard of the registered manager.

The registered manager present on inspection was new to Latham Court and the Scheme Manager was also relatively new and began working in their role there in August 2016. They therefore, relied upon staff for information about the service users as they were not aware of all the current risks and relied upon the staff for information. The staff were responsible for writing the care plans and risk assessments. When we requested an updated risk assessment for one person we were told by the Scheme Manager that the staff had not completed it as they would have wanted and were intending to write it themselves. We were therefore, concerned that the provider had not ensured staff who were responsible for crucial tasks such as undertaking assessments and reviews of care plans and risk assessments were being supported adequately to ensure they were appropriately trained to these undertake tasks.

We asked to see any audits or surveys undertaken by the service and we were provided with a copy of the Service Quality Survey Results 2016. The survey had been completed in May 2016 and out of 34 surveys issued only seven had been returned which was twenty percent of the people receiving care. There was no action plan available for us to view as to what the service intended to do with the information obtained.

We asked about the oversight and what systems were in place to ensure information is passed on to the Regional Manager and we were provided with a copy of the most recent Monthly Branch Return Report available for us to view. The "Main Actions" section of the minutes listed the actions needed within the

service. We were concerned the minutes stated – "Care Planning– No Actions" in view of the concerns highlighted with the lack of detailed information within the care plans. We were also concerned the report stated staff needed refresher training but it did not specify the training needed and by which staff so was not specific enough.We also viewed a copy of an internal audit dated 7 September 2016 which stated "Senior staff to attend fields management systems training. Identify all inadequate care plans/risk assessments. All completed care plans to be reviewed by senior office staff and deemed correct". Although this audit comments on the need to identify which care plans were inadequate, there was no further action points to demonstrate when a further audit of the care plans was taking place or by whom. Therefore, we were concerned that not all the issues highlighted as part of the inspection such as poor documentation, staff not always reporting incidents/Safeguarding and lack of staff knowledge about Mental Capacity Act 2005 legislation had not consistently been identified through the service's own quality assurance checks with clear action points.

The issues detailed in the report that the scheme manager and Regional Manager were aware of such as problems related to staffing had been identified by the service since at least August 2016, however, appropriate action including a review of staffing according to the care needs of people at Latham Court had not been actioned.

This is a Breach of Regulation 17 Governance of the Health and Social Care Act Regulations 2014.

The Commission were receiving Statutory Notifications but at times they were submitted following our request rather than being initiated by the provider.
Since our inspection a team of senior staff were deployed to Latham Court to provide additional training for staff, review care plans and ensure systems of recording and reporting incidents/safeguarding concerns are improved. We have received an action plan from the provider to address the issues highlighted from the inspection.