Housing 21

Housing & Care 21 - Olive House

Inspection report

185 Townmead Rd
Imperial Wharf
Fulham
SW6 2JY

Tel: 03701924676
Website: www.housing21.co.uk

Date of inspection visit:
08 February 2019
15 February 2019
18 February 2019

Date of publication:
23 April 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:

Olive House is a supported living service for older people, some of whom have dementia, mental health issues or other physical or learning disabilities. This service provides care and support to people living in 50 flats within a 'supported living' setting and there were 36 people receiving personal care.
For more details, please see the full report which is on the CQC website at www.cqc.org.uk

People's experience of using this service:

•People gave good feedback about care staff and told us they were kind and caring. However, relatives told us they thought understaffing was an issue that was affecting the delivery of care. We observed that the service was understaffed by three care staff on the second day of our inspection.
•People did not have any concerns about the competence of their care staff. However, records indicated that care staff did not have up to date training and were not being properly supported with supervisions.
•People did not have any concerns about the management of the service, however, relatives told us they felt the management of the service was poor. One relative told us communication about basic issues regarding the care of their family member was very poor. Another relative said they had noticed a decline in the service since the departure of the previous registered manager.
•People's feedback was not actively sought and acted on. Where the provider received a formal complaint, we found these were responded to appropriately. However, the provider did not effectively seek people's feedback on a regular basis and did not take action when advised of less formal concerns.
•People did not receive appropriate support with activities. The previous activities coordinator had left the service in January 2019 and since this time, there had been no effective provision for providing activities or ensuring that people were not at risk of social isolation.
•We found two breaches of regulations in relation to staffing and providing care staff with appropriate support. You can see what action we told the provider to take at the end of the full version of this report.

Rating at last inspection: Good. (report published 09 August 2016).

Why we inspected:

This was a planned comprehensive inspection based on the rating at the last inspection. The previous inspection was a comprehensive inspection.

Follow up:

We will ask the provider to tell us how they will make changes to ensure they improve the rating of the service to at least Good. We will continue to monitor information and intelligence we receive about the service until we return to visit as per our re-inspection guidelines. We may inspect sooner if any concerning

information is received.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

Housing & Care 21 - Olive House

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 a single inspector over a period of three days.

Service and service type:

Olive House is a supported living service for older people, some of whom have dementia, mental health issues or other physical or learning disabilities. There are 50 self-contained flats at the service. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. There were 36 people receiving personal care when we visited.

The service did not have a manager registered with the Care Quality Commission working within the service at the time of our inspection. A registered manager is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:

The inspection was unannounced. We visited the office location on 8, 15 and 18 February 2019 to see the

manager and office staff; and to review care records and policies and procedures.

What we did:

Before the inspection; We reviewed the information we held about the service which included the previous inspection report and the Provider Information Return Form (PIR). The PIR 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.

During the inspection:

- We spoke with five people using the service and two of their relatives.
- We spoke with four care staff two assistant care managers, the newly appointed interim care manager of the service and two members of senior management within the organisation.
- We also spoke with a social worker during our inspection.
- We looked at a sample of five people's care records, four staff records and records related to the management of the service.

After the inspection we spoke with another social care professional from the local authority to obtain their feedback.

Requires Improvement

Is the service safe?

Our findings

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

Requires Improvement: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.
Staffing and recruitment

•Care staff reported concerns about the numbers of staff on duty at any time. On the second day of our inspection we found the service had three fewer staff members than had been scheduled. We spoke with the senior member of staff, known as the assistant care manager and they told us the reason for this was staff sickness that they had been unable to cover.
•Care staff reported that understaffing had been a consistent issue for months and this was not an unusual occurrence. They told us that due to the pressures of working with fewer staff they were unable to provide care to people in a timely manner.
•A relative told us they were concerned that understaffing was impacting negatively on the delivery of care. They expressed concern that their relative was now getting out of bed very late when they had not done so previously. We spoke to this relative's family member on the second day of our inspection and saw that they were still in bed at 11.20am. The person told us it was their choice to remain in bed, but care staff told us that in any event they had not had the time to provide them with assistance to get out of bed before this time.
• The above issues constitute a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.We spoke with senior management about the staffing concerns and they agreed to investigate this further and take appropriate action.
•The provider conducted safer recruitment practices as appropriate checks were undertaken before staff began working for the service. We reviewed four staff files and saw these contained evidence of identity checks, a full employment history, references and a criminal record check.

Systems and processes to safeguard people from the risk of abuse

•The provider had appropriate systems in place to identify and safely manage allegations of abuse. Care staff had a good understanding of how to identify signs of abuse and had received training in this area. Care staff told us they would report any concerns they had to their manager and ensure that appropriate action was taken.
•We reviewed the provider's safeguarding records and found allegations were reported to the local authority to conduct investigations as required. We found the number of safeguarding incidents was proportionate to the size of the service.

Assessing risk, safety monitoring and management

•Risks to people's health and safety were appropriately assessed and risk assessments were in place which included advice for care staff about how to mitigate these.

•People's care records included risk assessments in areas such as their risk of falling or their risk of developing a pressure ulcer. Risk assessments included clear guidance for care staff to follow. For example, we saw one person's falls risk assessment included advice such as ensuring that their environment was clear of clutter and that they appropriately supervised the person when they were mobilising.
•Care staff had a good understanding about risks associated with people's care and gave us examples of how they ensured people were safe. For example, one care worker told us which people were at risk of falling, how they ensured people were safe and which people used equipment when mobilising.
•Where people used equipment such as wheelchairs for mobilising, we found appropriate checks were undertaken to ensure these were safe for use.
•The provider conducted environmental risk assessments to assess the safety of people's flats. Assessments included a check of the electricity, lighting and flooring to ensure they were safe. The assessments we reviewed did not identify any issues. Care staff confirmed they would report any concerns about people's flats to senior staff, known as 'assistant care managers'. For example, we saw one person's flat which was significantly unkempt. We found this had been reported to the assistant care managers and they were liaising with the person's social worker in order to manage this.

Using medicines safely

•People's medicines were managed safely. We found medicines were delivered to the service for people on a monthly basis and were usually delivered within blister packs.
•People required varying levels of support with their medicines, with some people requiring no support at all and others requiring timely assistance to take their medicines. Where people required assistance, we found medicines administration records (MARs) were filled in as required.
•Medicines were stored in people's flats. We reviewed five people's medicines with their permission and found MAR charts were appropriately filled in and stated what medicines people were required to take and when. We checked the medicines these people had and found the amounts remaining tallied with the amounts they ought to have taken as recorded on their MAR charts.
•Care staff had received training in administering medicines and we found this had been delivered in a timely manner.

Preventing and controlling infection

•The provider followed good infection control practices. We saw the communal areas of the building were clean and cleanliness was maintained throughout the day when needed.
•We saw people's rooms were tidy and people told us care staff conducted a weekly clean of their rooms or more often if requested.
•Care staff had a good understanding of appropriate infection control practices. We saw care staff wearing personal protective equipment such as gloves and aprons as needed and they told us they changed these as required.

Learning lessons when things go wrong

•The provider ensured lessons were learned when things went wrong as appropriate investigations were conducted into accidents and incidents and safeguarding matters.
•Where incidents occurred, records were made on the internal incident recording system. These records contained details of what happened, whether there were any witnesses, what immediate action was taken as well as follow up actions. Where there were witnesses to incidents, we saw witness statements were taken as part of the investigative process.
•We checked accident and incident records and saw action was taken to minimise the risk of a repetition.

For example, we saw one instance of a missed call was investigated. The senior person in charge of the rota had made an error and the matter was discussed with them to ensure the error was not repeated.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.
Staff support: induction, training, skills and experience

•Care staff were provided with an appropriate induction that met the requirements of the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. Care staff told us they had received an appropriate induction and felt prepared for their roles once completing this.
•However, the provider did not consistently ensure that care staff were provided with ongoing annual training. At the time of our inspection most care staff had not received training in most subjects such as moving and handling and medicines management, since 2017. Care staff gave mixed feedback about when they had last received training in various subjects. Some could not remember when they had last received a training session and others told us they were up to date with their training.
•Records indicated that the provider was not up to date in providing care staff with supervisions and appraisals of their performance. Most care staff had not yet received their appraisal for 2018 and numerous staff had not received a supervision session in 2018. Some care staff told us they could not recall when their last supervision was and all care staff told us they did not receive appropriate managerial support to perform their role.

•This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

•The provider ensured care was delivered in line with relevant guidance and legislation. We reviewed some of the provider's policies and procedures and found these were up to date and were in line with applicable legislation.
•We spoke with the assistant care manager to find out how the provider ensured they met current legislation. They explained that up to date training was supposed to be given on an annual basis. However, we found the provider was not consistently providing care staff with annual training.

Supporting people to live healthier lives, access healthcare services and support

•People were provided with appropriate support in relation to their physical healthcare needs, but their care records were sometimes lacking in detail in relation to their mental healthcare needs.
•We saw two people's care records specified that they had experienced anxiety and depression, but there was no additional advice for care staff about how they were expected to manage this.

•We found there were detailed records kept of people's physical healthcare needs. This included a history of health conditions they had in the past as well as further information about how this affected their current abilities. For example, we read that one person had dementia. We saw a written description of how this affected them as well as written advice for care staff about how they were expected to care for this person. For example, the person was prone to neglecting their self-care, so care staff were advised to remind the person about this.

Supporting people to eat and drink enough to maintain a balanced diet

•The provider gave people appropriate assistance with their nutritional needs. People told us they liked the food available and the provider accommodated their tastes. One person said, "If you don't like the food you can always ask for something else" and another person said, "The food is good here."
•We spoke with the head chef about the food prepared within the service. At the time of our inspection, nobody using the service had complex nutritional needs, but some people had specific allergies. The chef was aware of what these people's allergies were as well as the effect consuming these products would have. Food was seasonal and prepared in consultation with people using the service.
•People's care records included details about their nutritional needs. People's likes and dislikes in relation to food was clearly recorded. For example, one person's care record stated they enjoyed breakfast cereals with cold milk for breakfast. Where people required additional support, this was also specified. For example, one person's care record stated they needed to be reminded about mealtimes.

Staff working with other agencies to provide consistent, effective, timely care

•People's care records included details of other agencies that were responsible for aspects of people's care. For example, we saw one person received weekly visits from district nurses. Their record stated when the nurses came and what their responsibilities were in relation to the person's care. Another person's record stated that they were also under the care of a community psychiatric nurse. Their record included the details of the nursing team as well as further information about when care staff were required to contact them.

Ensuring consent to care and treatment in line with law and guidance

•The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA and found the provider was meeting their obligations.

•People had signed their own care records and where they had not done so, we found only those with Power of Attorney for health and welfare matters had done so in order to demonstrate that they consented to the care being provided on the person's behalf.
•People had also signed specific consent forms to demonstrate that they consented to the sharing of their information with authorised persons regarding their healthcare needs as well as a consent form authorising care staff to enter their flats for the purposes of providing them with care.
•Care staff had a good understanding of the need to obtain consent on a daily basis as well as the signs that someone was lacking in capacity. One care worker told us, "We always get permission before we do anything. Just because someone has signed a consent form or just because they let you do something yesterday, doesn't mean you can do it today" and another care worker said, "We know our residents and if someone doesn't seem like they have capacity to make a decision, we would notice and report this."

Good

Is the service caring?

Our findings

Caring– this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

•People gave good feedback about the care staff and told us they listened to them. People's comments included "They're very helpful" and "They are kind and caring... they're all nice."
•Care staff had a good understanding about people's individuals needs and their routines. Care staff gave us examples of people likes and dislikes in relation to the clothes they liked to wear, the food they ate and the times at which they got up in the morning and went to bed at night. One care worker told us "It's important to remember these details as it really helps the relationship."
•Care records included personalised details about people's preferences in the way they wanted their care delivered and their personal histories. People's care records included an 'All about me' section which specifically included these types of details. For example, we saw one person's 'All about me' section stated where they were originally from, how long they had been married and how many children they had as well as where they had previously lived and the current status of their relationship. Another person's care record stated that the person liked to converse with care staff and particularly enjoyed sharing a joke with them.
•Care records included information about people's cultures and religions and specified whether they had any particular cultural needs. For example, we saw one person's care record gave details of their religion and how this related to matters such as their personal care and the food they were able to eat.

Supporting people to express their views and be involved in making decisions about their care

•Records indicated that people using the service and those important to them were involved in making decisions about their care. Records contained personalised details about people and people and their relatives told us they had been involved in the care planning process.
•People's care records included information about their communication needs along with specific advice for care staff about how they should communicate with them. For example, we saw one person's care record gave details of the person's physical health condition and stated how this affected their speech. Care staff were advised to speak with this person slowly and allow them adequate time to respond.

Respecting and promoting people's privacy, dignity and independence

•People told us their privacy and dignity was respected and promoted. People's comments included "Yes they do respect me" and "They are respectful." Care staff gave good examples of how they supported people in a dignified way. One care worker told us "When I'm giving personal care I make sure the curtains and the door is closed" and another care worker said, "Some people find personal care a bit embarrassing, so it is really important to build trust and treat people the way you would want to be treated."

•We observed care staff interacting with people throughout our inspection. We found interactions to be polite and respectful and we observed care staff knocking on people's doors and waiting for a response before entering their flats.
•The provider supported people to be independent. Care records included information about people's specific abilities in relation to activities of daily living and included details of the support people needed from care staff. For example, we read in one person's care plan that they were able to perform personal care tasks on their own, but needed care staff to remind them to do so as they were at risk of neglecting their personal care.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Requires Improvement: People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

•People were not being supported to take part in meaningful social and leisure activities. People's care records contained information about people's interests. For example, we read very detailed descriptions about the types of books people liked to read and how they liked to spend their free time. However, we were informed that the activities coordinator had left at the end of January and their role was being performed by a care worker. They told us they were only supporting people to participate in two activities on two days a week and there was a knitting club activity conducted by a volunteer who attended the service. Therefore, there was a lack of opportunities for people to take part in activities that met their needs.
•The care worker told us that these issues had been reported to the management of the service and they were "Looking into it." We contacted the provider and they told us that they were in the process of recruiting a replacement activities coordinator.
•Care records included details about different aspects of people's care needs. Whilst we saw limited information about people's mental health needs, we saw a good level of personalised information about people physical healthcare needs, risks associated with their care and their interests. We saw people's care records included a timetable of tasks that care staff were expected to carry out and specific instructions related to managing risks and people's preferences. This included instructions about the way people liked to have their meals.

Improving care quality in response to complaints or concerns

•The provider had an effective complaints policy and procedure in place. People told us they were aware that there was a complaints procedure in place and they knew who to complain to if needed.
•We reviewed records of complaints and found these were recorded and investigated appropriately. For example, we saw one record of a complaint from a relative relating to the untidiness of one person's room. We read that the manager had arranged for this person's room to be tidied straight away in accordance with the relative's wishes.
•Records indicated that very few formal complaints had been received since our last inspection and these were all responded to appropriately.

End of life care and support

•At the time of our inspection, the provider was not supporting anyone at the of their life.

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.

Requires Improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support with openness; how the provider understands and acts on their duty of candour responsibility; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

•Leaders did not have the skills or knowledge needed to lead the service effectively. At the time of our inspection, there was no registered manager within the service as they had left very suddenly. As a result, the responsibility for managing the service had fallen to the next most senior staff members, both of whom were relatively new and had not received the appropriate training for the roles they were now performing. One of these staff members told us "I'm trying my best, but there should be three of us and a registered manager" and the other staff member said, "We are overwhelmed with work, so we have to prioritise the people first and make sure they're safe and then think about other things."
•Senior staff members did not take appropriate action to improve morale within the service. The lack of registered manager within the service was having a significant impact on staff morale. One care worker told us "If I have a question about anything, I either try to figure out the answer myself or I ask a colleague" and another care worker said, "We don't really have anyone to turn to right now. I feel like leaving, but I'm staying for the service users."
•We spoke with senior staff members who had been given managerial responsibility, known as assistant care managers, about the concerns raised about understaffing and a lack of appropriate management within the service. They explained that they understood the concerns expressed by staff, but they were also overwhelmed with work. They told us they had reported these concerns to senior management within the organisation who had responded by providing an interim manager to attend the service two days a week. We spoke with senior managers about these concerns and they explained that the sudden departure of the previous registered manager could not be avoided. They stated that they were investigating the issues raised and would take remedial action as soon as they were able. In the meantime, they had hired an interim manager to bring stability to the service. This manager was working their first day on the second day of our inspection.
•Care staff had a good understanding of their roles. They explained that they were provided with job descriptions prior to starting their role and the roles had met their expectations.
•Providers are required to notify the Care Quality Commission (CQC) about significant incidents including safeguarding concerns. We found the provider was meeting its obligations to report significant incidents to the CQC.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

•The provider did not effectively involve people using the service and their relatives. We reviewed a copy of the provider's feedback survey for 2018. We found this survey related to 68 care services run by the provider within the South and Central East of the United Kingdom. Therefore, the feedback obtained was not specific to the people using the service.
•Relatives expressed concerns about the provider's engagement with them. One relative told us communication about basic issues regarding the care of their family member was very poor and the other relative said they had noticed a decline in the service since the departure of the previous registered manager as they struggled to get adequate answers to minor queries.
•The provider was aware of feedback that had been obtained by us during our inspection. Since this feedback did not constitute a specific complaint, but was more general feedback about service delivery, we found this was not used to undertake effective learning.

Continuous learning and improving care

•The provider had conducted quality monitoring which had identified some issues, but had not implemented plans to rectify these. We reviewed a comprehensive audit that had been conducted at the service in October 2018. This mirrored the Care Quality Commission (CQC) inspection process and was based upon the CQC key lines of enquiry. The audit identified the issues regarding staff training, but did not include details of the issues with the management of the service as it predated the departure of the registered manager.
•The provider confirmed that they were going to take action to rectify the identified issues, but had not yet had sufficient time to do so.

Working in partnership with others

•The provider worked in partnership with other organisations. We saw evidence in care records of appropriate liaison with external professionals including social workers and district nurses. We spoke with two social workers and they confirmed they had a good working relationship with staff at the service.

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 HSCA RA Regulations 2014 Staffing The provider did not always ensure there were sufficient numbers of suitably qualified, staff to provide people with care and support. The provider did not always ensure that care staff received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they were employed to perform. Regulation 18 (1) and (2)(a).