Housing 21

Housing 21 - Rohan Gardens

Inspection report

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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
Rohan Gardens has 42 apartments. People living at Rohan Gardens share on-site facilities, such as lifts, lounge, restaurant, laundry and garden. People who need support with personal care are free to choose Housing and Care 21 - Rohan Gardens or any other domiciliary care service as their provider. At the time of this inspection, the service supported 17 people with personal care.

People's experience of using this service and what we found
Risks associated with people's health and care needs were not always assessed and governance systems to monitor the quality and safety of the service required improvement.

The registered manager and provider had failed to maintain sufficient oversight of the service, to identify that risk management was not consistently effective or in place.

Some audits were in place, but they were not robust enough to ensure areas for improvement were identified and action taken in a timely way. Staff did not always have the training or information they needed to consistently reduce risks of potential harm or injury to people. Care plans were not regularly reviewed or updated to contain all the information needed by staff to support people safely.

Improvements were needed related to risks of cross infection between people. We found the provider was not always following government guidelines associated with COVID-19. Improvements had been made to infection prevention and control practices following support from the local authority (LA) and the local clinical commissioning group (CCG). However, further improvements were still required to keep people as safe as possible and minimise infection control risks associated with COVID-19.

There were enough staff on shift to meet people's agreed care calls, but staff told us there had been numerous occasions when staffing levels at night needed to be increased to allow them to support people in a safe and more dignified way.

There had been recognition that some aspects of medicines management required improvement following reported medicine administration errors. Improvements had been made. Staff received assessments on their competency and skills in supporting people with their medicines.

Overall, people spoke positively about the care staff and the care they provided. However, people felt improvements were needed in the management team. Staff did not feel consistently supported by the management team.

The registered manager was registered with us for Rohan Gardens and another Housing and Care 21 service. However, we were told the registered manager was not based at Rohan Gardens and had not visited since November 2020. The registered manager had failed to inform us of their absence as they are required to do

so. We found there was a lack of support from the registered manager and provider to the Housing and Care Manager who had day to day responsibility for the management of Rohan Gardens. The Housing and Manager was open and explained this was their first managerial role and they had struggled with some aspects of their role because systems and processes were not in place at Rohan Gardens.

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

Rating at last inspection
The last rating for this service was good. (Report published 24 October 2018).

Why we inspected
Prior to our inspection, we had received whistle-blowing concerns about infection prevention control management, the safe handling of medicines and reduced staffing levels at night. These concerns were looked at as part of our inspection. We were aware of an on-going police investigation into a safeguarding concern, however this was not a part of our inspection as this matter is being handled by the police.

We joined a multi-disciplinary meeting with the local Clinical Commissioning Group (CCG) and the local authority (LA). They gave immediate support and guidance related to infection prevention control.

We undertook a focused inspection to review the key questions of 'Safe' and 'Well-led' only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Housing and Care 21 – Rohan Gardens on our website at www.cqc.org.uk.

The overall rating for the service has deteriorated to requires improvement. This is based on the findings at this inspection.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified two breaches of the regulations in relation to the safety of people's care and the management of the service. We have identified a further breach of the registration regulations in relation to the registered manager's legal duties to notify.

Please see the action we have told the provider to take at the end of this report.

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

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.

Housing 21 - Rohan Gardens

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 was 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.

Inspection team
The inspection was carried out by two inspectors. One inspector gathered information from the Housing and Care Manager via telephone conversations and email and spoke with people using the service and staff over the telephone. The other inspector undertook an on-site visit to Rohan Gardens.

Service and service type
Housing and Care 21 – Rohan Gardens is registered to provide personal care to people living in a specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented or purchased on a shared ownership scheme, and it is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection only looked at people's personal care services.

Housing and Care 21 – Rohan Gardens also provide an on-call emergency service to everyone living in the building under a separate arrangement which people pay for as part of the service charge for the shared premises.

The service had a manager registered with the Care Quality Commission. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

Our inspection was announced. We gave short notice of our visit on 27 January 2021 to the Housing and Care Manager. Notice of our visit was given because the service was inspected during the coronavirus pandemic and we wanted to be sure we were informed of the service's coronavirus risk assessment for visiting healthcare professionals before we entered the building.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection and recurrent themes of any concerns. Feedback was shared with us from the Local Authority (LA) and local Clinical Commissioning Group (CCG). This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
During our on-site visit to the service, we spoke with the Housing and Care Manager. We reviewed three people's care plans in detail and three people's medicine records. We looked at a sample of records relating to the management of the service, policies and procedures and a sample of completed audits and checks.

During our off-site work we spoke with nine people, one assistant manager and five care staff.

After the inspection
We reviewed additional documentation we had requested from the Housing and Care Manager. We continued to seek clarification from the Housing and Care Manager to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant 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.

Assessing risk, safety monitoring and management
• Risk of potential harm or injury was not always identified, assessed and well-managed. Where people had risk assessments and risk mitigation plans in place for known risks, care records were detailed and gave staff the information of how they should support people safely.
• However, some people who had diagnosed health care conditions had no care plan, risk management plan or information available for staff to refer to about risks associated with their condition. One person had a diagnosis of epilepsy. Staff had no information available to them about this person's needs. Following our inspection visit, the provider explained staff had received epilepsy training as part of their 'Basic life support training.' However, this training may not be effective because when we asked a staff member about the actions they would take in the event of the person having a seizure, they described unsafe practices which posed immediate risks of harm and injury to the person.
• Some people had urinary catheters in place. The was no catheter care plan or information about the management of the catheter and there was no guidance for staff about monitoring for early signs of infection, to help prevent ill-health. One person told us staff were due to support their catheter care in three days- time, but the Housing and Care Manager was unaware of this support need and staff had not received training in catheter care.
• There was no diabetes risk management plan for a person with diabetes and there was no guidance to alert staff to the signs of any changes in blood sugar levels or what action to take in such circumstances. Staff had not received training in diabetes care.
• Care records were not updated when people's needs changed.

Preventing and controlling infection
• Prior to our inspection we had received whistle-blowing information of concern related to an outbreak of COVID-19 at the service and concerns about the provider and managements handling of the outbreak.
• Staff told us detailed infection prevention control training including information about COVID-19, effective handwashing and donning and doffing of personal protective equipment (PPE) had not been provided to them. Following our inspection visit, the provider explained staff had received training in donning and doffing PPE as part of their medication awareness training in November and December 2020. This meant training may not be effective, because staff could not tell us the correct sequence in which to put on and take off PPE in order to reduce risks of cross infection. Following a multi-disciplinary team meeting in January 2021, the local clinical commissioning group (CCG) arranged dates to facilitate this training for all staff in February 2021.
• Staff told us there was a poster on display for effective hand-washing techniques and the use of PPE, however, they had not received any assessment of their competency on using PPE. A failure to train and

assess staff's knowledge posed risks of cross infection and potential harm and ill health to people.

Systems and processes were not sufficient to demonstrate risk associated with people's care and cross infection was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• Most staff had received training about the different types of abuse. Staff told us they would escalate any concerns they had to the Housing and Care Manager, who told us they would escalate further within Housing-21 for investigation. The Housing and Care Manager had shared details of a safeguarding incident they had reported to the police, which was ongoing, this demonstrated their awareness of the importance of reporting concerns.

Staffing and recruitment
• People told us staff attended their care calls at the agreed times and had not experienced any missed calls. Two people told us they had recently been told there were insufficient staff to undertake their call at the agreed time and both people had chosen to cancel the call rather than reschedule. The Housing and Care Manager explained this was due to mass COVID-19 testing being undertaken on a specific day as directed by a public health doctor.
• The current rota showed there were enough staff on shift to meet people's care needs. However, staff told us about numerous recent incidents when staffing had been low. One staff member told us, "I have turned up for many recent night shifts to be told I am working alone, there should be two wake-in staff. It's unsafe practice." Another staff member said, "There are some people who require two staff to help them, but if I am on my own at night, I just have to do my best." The Housing and Care Manager said the recent short fall of staff covering night shifts had been due to lack of staff availability and staff isolating due to the pandemic. They assured us staffing issues were now resolved and full staffing was allocated to the rota.
• The provider's staff recruitment processes ensured staff were recruited in a safe way. Staff employment files reviewed showed pre-employment checks were completed as required.

Using medicines safely
• We looked at three people's medicine administration records (MARs) and found these had been completed accurately to show people had received their medicines as prescribed.
• Some of the processes to support safe medicines practice had recently been improved. The Housing and Care Manager had implemented a system where handwritten amendments to Medicine Administration Records (MARs) were now to be signed by the member of staff making them and countersigned by a second member of staff to confirm their accuracy. This reduced risk of medicine errors.

Learning lessons when things go wrong
• Accidents and incidents were recorded, and the Housing and Care Manager told us these were used to ensure people's safety and determine whether any further action was required to minimise the risk of future re-occurrence.
• The Housing and Care Manager displayed a commitment to learning where things had gone wrong. They acted straight away following support and guidance from the local authority (LA) and CCG in relation to infection prevention control measures. They sought to make improvement to the service following our feedback and immediately took action to source epilepsy and catheter care training for staff.

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.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care
• Risks associated with people's care were not always managed well and governance systems to monitor the quality and safety of the service required improvement. Audits to monitor care plans had failed to identify risks associated with people's health care conditions had not always been identified or managed well.
• Audits in place to monitor the health, safety and welfare of people were not always effective. The most recent provider audit dated October 2020, had identified areas for improvement and some actions had been implemented. However, they had not identified the concerns we found during our inspection visit.
• The Housing and Care Manager who had come into post during August 2020 and was responsible for the day to day management of the service, had received limited support from the provider following the outbreak of COVID-19 in December 2020. They had received some visits from their line manager, the Extra Care Manager during their induction period, however, visits had ceased in December 2020 when the outbreak occurred.
• The provider had failed to have sufficient oversight of the training needs of staff so as to ensure staff had the skills they needed to keep people safe and protect them from potential risks of harm. Despite offers from the local authority and local Clinical Commissioning Group (CCG) to deliver infection prevention and control refresher training in light of the COVID-19 pandemic, the provider had failed to take up any such offer on behalf of their staff.
• The provider was not always following government guidelines associated with COVID-19. The Housing and Care Manager shared the provider's pandemic policy, dated 22 December 2020 with us. This had not been reviewed and did not comply with the level 5 restrictions in place at the time of our inspection. The policy actions posed risks of cross infection to people because shared living areas, such as the communal lounge and toilet facilities, had remained open despite government guidance against any indoor mixing between different households. The Housing and Care Manager closed those facilities that remained open on the instruction of a public health doctor on 22 January 2021.

The above issues demonstrate a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The service had a registered manager who had been registered with us since July 2020. However, only one of the staff members spoken with had heard of this manager when we asked about them. Two staff

members told us they had worked at Rohan Gardens for over two years and had never heard of, or met, the registered manager.
• The Housing and Care Manager told us the registered manager had previously visited about once a week but due to the pandemic had stopped visiting in November 2020.
• The registered manager had failed to fulfil their legal duty to tell us about their absence from the service. The provider also had failed to inform us that the registered manager had been absent from the service for more than 28 days.

This was a breach of Regulation 15 of the Care Quality Commission (Registration) Regulations 2009.

• The Housing and Care Manager had reported numerous medication errors to us, which they had investigated. The Housing and Care Manager had recognised improvements were needed in the safe handling of medicines and had implemented staff assessments of skills and competencies.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The Housing and Care Manager recognised the need to improve opportunities for feedback. They had displayed posters informing people they could give feedback about the services. A feedback survey had previously been completed but had received such a low response, no analysis had been completed. No further feedback survey had been sent to people.
• Staff did not feel consistently supported by the management team at Rohan Gardens. One staff member told us, "It is a shambles, the managers really need to improve. Paperwork is poor, support to staff is poor, rota cover is not always good." Another staff member told us, "The management team are quite new, I think they are probably trying to improve, but they don't get to know the service users, they don't support care staff on care calls when needed, they just stay in the office most of the time."
• Both staff and people told us they felt communication from the management team at Rohan Gardens needed improvement. One person told us, "We get a note shoved under the door, and we've had updates about COVID-19, but no other communication about anything. I tried to cancel a care call and was still charged for it because of poor communication."
• People gave positive feedback about staff's caring approach to them. However, both people and staff told us they felt there had been a deterioration in the level of empathy and compassion shown by the management. One staff member told us, "I feel ashamed to say I work at Rohan Gardens, I only stay for the residents. One resident asked me to post a letter for them as they couldn't go outside due to the pandemic. The manager told me I couldn't do it unless we charged the person for a fifteen-minute call." Another staff member told us, "We've always tried to go the extra mile for the residents here, but now we get told off for that by the managers."
• One person told us, "Sadly it's all become about money and getting charged for everything here. One of the girls (staff) offered to get my prescription for me when they were passing the chemist, but then I was told I'd have to be charged. I understand we have to pay for services, but the attitude has changed."

Working in partnership with others
• Following a multi-disciplinary team meeting during January 2021, the Housing and Care Manager followed the guidance given to improve infection prevention and control.
• Evidence reviewed during our inspection showed the Housing and Care Manager made referrals to healthcare professionals such as an occupational therapist to source equipment to assist people with moving and handling.

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 15 Registration Regulations 2009 Notifications – notices of change The provider failed to notify us that the registered manager had been absent from the service for more than 28 days.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to the health and safety of service users were not always assessed. The provider had not done all that was reasonably practicable to mitigate any such risks. The provider had not ensured persons providing care to service users had the necessary qualifications, competence, skills and experience needed. The provider had assessed the risk of infection and control measures were not sufficient.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not always assess, monitor and improve the quality and safety of the service provided in the carrying on of the regulated activity. Risks relating to the health, safety and welfare of service users were not always mitigated.