

Housing 21

Housing 21 - Alice Bye Court

Inspection report

Alice Bye Court
Bluecoats
Thatcham
Berkshire
RG18 4AE

Website: www.housing21.org.uk

Date of inspection visit:
27 January 2021
28 January 2021

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05 March 2021

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

Housing 21 Alice Bye Court is a service which provides care and support to people living in specialist 'extra care' housing. People using the service lived in flats situated within one large building. Currently, the service provides care and support to 27 people. Not everyone using the service receives personal care. Care Quality Commission (CQC) only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. Whilst the service does not provide care and support to everyone living at Housing 21 Alice Bye Court, staff respond to all the residents if they activate their personal pendant alarms seeking assistance.

People's experience of using this service and what we found

The service management and leadership was inconsistent and did not always support the delivery of high-quality, person-centred care. Deficiencies identified during our last inspection had not been fully addressed and the provider had not effectively operated processes to ensure compliance with regulations. The management team did not always effectively operate quality assurance and governance systems to drive continuous improvement in the service. The management team had not promoted a person-centred, inclusive service which empowered staff to deliver good outcomes for people. Staff consistently told us they did not feel that the management team listened to them and had lost confidence in their capability to address concerns effectively.

People were at risk of harm because staff had not always administered medicines safely and people had not consistently received their medicines as prescribed. The provider had implemented a new policy and procedures to ensure medicines were managed safely and had appointed a medicine's champion. However, staff were not consistently following the new procedures. The provider had improved their reporting of medicine errors, which were now open and transparent. However, a high level of medicine errors continued to be made.

Staff had completed safeguarding and whistleblowing training and consistently understood how to report concerns when required. People experienced care from staff who were aware of people's individual risks. The registered manager completed a regular needs analysis based on people's dependency to inform the required staffing level to meet people's needs. There were enough suitable staff deployed to support people to stay safe and meet their needs. People had their assessed needs, preferences and choices met by staff with the right qualifications, skills, knowledge and experience. Staff had completed an induction process and did not work unsupervised until they were confident and assessed to be competent to do so. The provider was preventing visitors from catching and spreading infections, promoting safety through adapting the layout and hygiene practices within premises.

People were supported to have maximum choice and control of their lives and staff did them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The registered manager understood and complied with their duty of candour, to be open and honest when things went wrong. The registered manager had collaborated effectively with health care professionals to support people with mental health needs.

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

Rating at last inspection and update

The last rating for this service was requires improvement (published 2 March 2020) and there were two breaches of regulation. The service remains rated requires improvement. This service has been rated requires improvement for two consecutive inspections. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected

We carried out an announced comprehensive inspection of this service on 27 November 2019. Two breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

We undertook this focused inspection to check they now met legal requirements. In addition, we had received concerns in relation to the management and safety of the service provided. For these reasons this report only covers our findings in relation to the key questions of safe and well-led, which cover those requirements and concerns.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has remained the same. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

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

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

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 monitor the service.

We have identified breaches in relation to the safe care and treatment of people and good governance.

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

Follow up

We will meet with the provider following this report being published to discuss how they will make changes

to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 - Alice Bye Court

Detailed findings

Background to this inspection

The inspection

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

Inspection Team

This inspection was carried out by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

This service provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought or rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

Notice of inspection

This inspection was announced. We gave the service 48 hours' notice of the inspection visit. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 27 January 2021 and ended on 9 February 2021. We visited Alice Bye Court on 27 and 28 January 2021.

What we did before the inspection

We reviewed information we had received about the service since the last inspection, including notifications received from the provider. The law requires providers to send us notifications about certain events that happen during the running of a service. We sought feedback from the local authority and professionals who work with the service. We reviewed the provider's website. The provider was not asked to complete a

provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used this information to plan our inspection.

During the inspection

We spoke with 12 people who used the service and six relatives about their experience of the care provided. We spoke with 11 members of staff, including the registered manager, three assistant care managers and eight care staff, which included night staff and newly inducted staff.

We reviewed a range of records. This included six people's care records, medication records and daily notes. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were reviewed, including the provider's policies, procedures, quality assurance audits, accident and incident reports with associated safeguarding and care quality referrals to the local authority.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with five community professionals who engage with the service.



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 requires improvement. At this inspection this key question has remained the same.

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.

Using medicines safely

At our last inspection the provider had failed to manage medicines safely. The unsafe management of medicines meant people were exposed to the potential 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.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- People remained at risk of harm because staff had not always administered medicines safely and people had not consistently received their medicines as prescribed. For example, one relative described the adverse impact on their loved one who lived with Parkinson's disease, when staff failed to administer their medicine as prescribed. One person told us they had suspended support with their medicines because they kept finding their prescribed tablets just lying around on the floor. Another person told us, "They [staff] gave me my bedtime tablets as well as morning ones once so I had to go to hospital." Some people told us they did not receive their medicines at the right time. For example, one person said that staff sometimes forget their night-time medicine and wake them up at 02.00 and 03.00 am to take them or administer them in the morning. Another relative told us that staff sometimes forgot to change their loved one's medicine patch.
- Medicine administration records (MAR), CQC notifications, local authority safeguarding and care quality referrals, demonstrated there had been multiple medicine administration and recording errors since our last inspection. For example, one person was not administered their morning and lunchtime pain relief and Warfarin medicine. Warfarin is commonly referred to as a blood thinner which makes your blood flow more easily and helps to prevent dangerous blood clots. Another incident identified a person's medicines were running low and two staff members did not take appropriate action to ensure the medicine did not run out, necessitating an urgent prescription being obtained when the error was later identified.
- The registered manager and assistant care managers (management team) identified that agency staff had been responsible for some of the medicine errors. The management team demonstrated action they had taken with the agency providers to reduce the risk of repeat occurrence. This included the offer of additional training. However, the management team consistently agreed it was their responsibility to ensure agency staff did administer and record medicines safely, whilst working at Housing 21 Alice Bye Court.
- The provider had policies and procedures to ensure the safe management of medicines. However, staff had not always followed the provider's policies to ensure medicines were managed safely, in accordance

with current guidance and regulations.

- The provider had published a new medicines policy and procedure on 7 December 2020 to address these issues. The service had appointed one of the assistant care managers as the medicines champion responsible for implementing the new processes and delivering staff training. Staff confirmed they had completed the required training and had been observed and assessed to be competent to administer medicines under the new system. Most staff told us they understood the new system, although some found it confusing. The medicines champion believed that if staff embraced the new system this would have a significant impact on the safety of medicines management. However, the medicines champion had become aware that once assessed to be competent some staff did not always follow the new process. The medicines champion was developing a strategy to ensure staff followed the provider's new policy and procedure.
- The medicines champion believed the new system was having a positive impact on the level of medicine errors, although from 1 November 2020 to the date of inspection there had been 23 medicine errors, some of which related to multiple mistakes over a period of time.
- People were not always treated with dignity when supported with their prescribed medicines. Staff told us that some staff members applied creams directly on top of previous applications, without cleaning the area first. People told us that staff did not always listen to their wishes when staff applied cream.
- Local authority quality assurance teams and link workers told us the provider had improved their reporting of medicine errors, which were now open and transparent. However, they were concerned at the level of medicine errors which continued to be made.

We found no evidence that people had been harmed however, the unsafe management of medicines placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

- Since our last inspection the provider had improved recording and reporting of incidents when things go wrong. The provider had implemented a new safe management of medicines policy and procedure to reduce the level of future medicine errors. At the time of inspection, it was too early to assess the impact of the new system and processes.

Assessing risk, safety monitoring and management

- People experienced care from staff who were aware of people's individual risks. When people began to use the service, staff identified and assessed risks to people, which they had managed safely. For example, people had management plans to protect them from the risks of choking, malnutrition, falling and developing pressure areas.
- However, where accident and incident forms identified potential increased risks to people, these risk assessments had not always been fully reviewed. The registered manager completed weekly audits of people's care plans and risk assessments. They had identified one person's falls risk assessment that required to be updated in relation to recent falls they had experienced. At the time of inspection this risk assessment had not been updated. The registered manager agreed to expedite the completion of the reviewed risk assessment.
- When people experienced behaviour which may challenge others, staff supported them in a sensitive way and protected their dignity and human rights. The manager and staff had effectively engaged with the community psychiatric nursing team and regularly reviewed the support provided to manage people's anxieties and behaviour. Healthcare professionals praised the commitment of the registered manager to support people living with mental health needs and encouraged the provider to provide additional staff training in relation to supporting people with mental health needs.

Staffing and recruitment

- The registered manager completed regular staffing needs analysis based on the dependency of people and hours of care commissioned. At the time of inspection rotas demonstrated there were sufficient numbers of suitable staff deployed to support people to stay safe and meet their needs.
- People and staff told us there had been an extremely high level of dependency on agency staff, which had an adverse impact on the continuity and consistency of care. Some people were unhappy with inconsistent and sometimes unfriendly staff, whom they believed to be agency staff. Some people told us they had experienced missed and late calls, with staff not always staying for the full time of their commissioned care.
- In October 2020, the provider held a recruitment drive and recruited nine new staff members. The week prior to our inspection the necessity to deploy agency staff had ceased. People and staff told us staffing had improved since the recruitment of new staff, although some of the new staff were relatively inexperienced.
- The provider had completed thorough pre-employment checks to make sure staff were suitable and had the appropriate character to support older people and those living with dementia. These included prospective staff's conduct in previous care roles and their right to work in the UK. Where required the registered manager had completed necessary risk assessments to support staff with underlying health conditions.
- People had their assessed needs, preferences and choices met by staff with the right qualifications, skills, knowledge and experience. Staff had completed an induction process and did not work unsupervised until they were confident and assessed to be competent to do so by the management team. Schedules demonstrated that staff training was up to date.

Systems and processes to safeguard people from the risk of abuse

- People did not always feel safe and trust the staff who supported them. We received a mixed response from people when asked how safe they felt at Alice Bye Court. Some people told us they felt very safe with their regular staff. However, others did not always feel safe, particularly with new staff. One person told us, "They are fantastic. I had a fall in the lounge, I pressed my button on my bracelet, and they came quickly. They stayed with me for quite a while." When asked whether their loved one was safe, one relative told us, "Currently not really to be honest. Where we can trust the carers, they [staff] are fantastic but when they do blip, it's quite a bad blip. I just want to know she's safe." Other people told us staff did not always respond promptly when called. One family member said, "Sometimes we've had to buzz twice for help. They don't always come quickly."
- The provider had systems, processes and practices in place to protect people from abuse, neglect, harassment and breaches of their dignity and respect.
- Staff had completed safeguarding and whistleblowing training and consistently understood how to report concerns internally. Some staff did not recall how to report concerns to external agencies when required.

Preventing and controlling infection

- We were mostly assured that the provider was preventing visitors from catching and spreading infections. All visitors and people entering Alice Bye Court were encouraged by the provider to wash their hands, in line with guidance, before they were able to access other areas of the service. The provider was promoting safety through adapting the layout and hygiene practices within premises.
- Staff adhered to the provider's infection control policy and used PPE in line with guidance. However, there was confusion as to whether staff should be wearing a visor in addition to a face mask. Some staff were wearing a visor, while most were not. People, especially those with high anxieties had not been informed why some staff were now wearing face shields.
- Some people were concerned that staff did not wash their hands when entering their homes, as per the provider's notice on the back of their doors and were worried Covid-19 may be brought into their homes.
- The registered manager and provider were proactively endeavouring to access Covid-19 testing for all

staff. Some staff had arranged Covid-19 testing independently. Staff effectively supported people to attend appointments to receive Covid-19 vaccinations and other important healthcare appointments which could not be completed using technological solutions.

- Staff had completed food safety training and correct procedures were followed wherever food was prepared. Staff had identified an unsafe process implemented by one person's family members in relation to the provision of food from their freezer. The person's support plan had been updated detailing the method to provide the person's food safely.

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 requires improvement. At this inspection this key question had remained the same. 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

At our last inspection the provider had failed to consistently assess, monitor and improve the quality of the service and to effectively operate systems and processes to ensure compliance with the regulations. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- At our last inspection people had been exposed to the risks associated with the unsafe management of medicines. Staff had not consistently administered medicines safely and people had not always received their medicines as prescribed. Staff had not consistently followed the provider's policies and procedures to ensure medicines were managed safely, in accordance with current guidance and regulations. At this inspection we found the unsafe management of medicines still placed people at risk of harm, which was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's failure to consistently assess, monitor and improve the quality of the service and to effectively operate systems and processes to ensure compliance with the regulations was a continued breach of regulation Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The management team did not always effectively operate quality assurance and governance systems to drive continuous improvement in the service. For example, the registered manager completed multiple weekly audits of care plans and risk assessments and assured us that all deficiencies highlighted and areas for improvement had been addressed. However, these audits were not recorded to demonstrate what improvements were required and to confirm these had been made. For example, the registered manager had identified one person's falls risk assessment required updating after a sequence of falls. They were able to explain what improvements were required and told us they had designated an assistant care manager to complete a review of the risk assessment. However, there was no record of the audit or the action required

by the assistant care manager or the updated risk assessment. Staff were aware of the increased risks to this person and understood the increased support they required to provide to mitigate the risks.

- In July 2020 an incident was reported to the management team, where a staff member had signed a medicine administration record indicating they had changed a person's catheter bag, which they had not done. The registered manager designated an assistant care manager to ensure the person's catheter bag was changed. The assistant care manager directed a staff member to complete the task. The management team did not check to confirm the catheter bag had been changed. The staff member did not change the catheter bag, which was later discovered and reported by another staff member, who changed the bag. The person experienced no harm in relation to these events but had been exposed to the risks associated with poor catheter care.
- The provider had completed a staff survey to address staff dissatisfaction identified during our last inspection. The results of this survey were not subject to any analysis and the provider's response focused on the performance of an individual member of the management team. Other concerns raised regarding the quality of care being delivered to people were not acknowledged or addressed.

The provider's failure to consistently assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk was a further breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.

- The registered manager had not promoted a person-centred, inclusive service which empowered staff to deliver good outcomes for people. The registered manager and assistant care managers did not cooperate or work effectively together to present a united front. Staff members told us that relationships amongst the management team had deteriorated beyond repair. The assistant care managers told us they had not been supported with their personal development by the registered manager, for example; through guidance and completion of the assistant care manager's development toolkit.
- Support for staff from the management team was inconsistent and staff morale was low. Staff consistently told us they did not feel listened to, respected or valued. The registered manager, assistant care managers and staff identified that communication was an issue and needed to be improved. Staff consistently told us that whenever they had raised issues with the management team, no action had been taken and they had no confidence in them. For example, one staff member said, "The management isn't good. It's a good day when you don't have to raise something but when you do it falls on deaf ears or they make you feel like a burden, so don't feel confident to raise issues."
- The provider had completed a staff satisfaction survey in May 2020 and subsequently held a team meeting to discuss the findings. One assistant care manager addressed the issues raised in the survey, apologised to staff and detailed actions to be taken to improve the support provided to staff by the management team. Staff consistently told us that nothing had changed since this team meeting.
- The management team were not highly visible and did not consistently provide clear and direct leadership. Some new staff believed one of the assistant care managers was the registered manager. Staff consistently told us they had not received constructive feedback when things had gone wrong and felt the management team always sought to deflect their accountability and responsibility.
- Staff consistently told us they were not actively encouraged by the management team to be involved in considering and proposing new ways of working, including ways of putting values into practice.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider's policy clearly identified the actions the registered manager and staff should take, in

situations where the duty of candour applied.

- The registered manager understood their duty of candour, to be open and honest when things went wrong. Most people and relatives who had raised concerns told us the registered manager and provider had listened to their concerns, apologised where necessary and took had taken action to address the concern. However, one relative told us they were happy with the quality of care being provided by regular care staff but had lost confidence in the management of the service.

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

- People told us their feedback had been sought in a survey completed by the provider, but they had not been updated with the outcome. Most people cited the lack of communication with the management team as the main area for improvement.
- People did not always think that the registered manager and management team listened and acted on their feedback.

Continuous learning and improving care

- At our last inspection incidents and accidents were not always responded to in an open manner and legal requirements to report certain incidents were not always met. At this inspection we found the reporting of accidents and incidents had improved and was much more open and transparent.

Working in partnership with others

- The registered manager had worked effectively in partnership with community mental health teams to support people who had mental health needs and those who experienced behaviours which may challenge others.
- The registered manager did not feel well supported by local authority quality assurance who had engaged with the service in relation to the high level of medicine errors.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met:</p> <p>The unsafe management of medicines placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>Regulation 12 (1)(2)(g)</p>
Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>How the regulation was not being met:</p> <p>The provider's failure to consistently assess, monitor and improve the quality of the service and to effectively operate systems and processes to ensure compliance with the regulations was a continued breach of regulation Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>Regulation 17(1)</p> <p>The provider's failure to consistently assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk was a further breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations.</p>

