

Peabody Trust

148 Hornsey Lane

Inspection report

148 Hornsey Lane
Islington
London
N6 5NS

Tel: 02072723036

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05 November 2020
20 November 2020

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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

148 Hornsey Lane provides accommodation and personal care to people with long-term mental health needs. The service accommodates 12 people across three floors. At the time of our inspection there were 11 people using the service.

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

During this inspection we found that the management team needed to improve the oversight of the service provision. The provider needed to ensure that all aspects of the service were regularly and effectively monitored and that the service was provided in line with the current government guidelines and legislation.

We found improvements were required in relation to the infection prevention and control, risk assessment, management of medicines and staffing. Further areas for improvement related to analysing and acting on feedback from people and overall monitoring of the service. We noted that improvements had been made between our visits on 5 November and 20 November and these were related to infection prevention and control.

People and relatives said people felt happy and safe at the service. External health and social care professionals said staff were kind and caring.

The recruitment procedures for staff employed directly by the provider were safe. Staff understood their role in safeguarding people from harm from others. There were appropriate accidents and incidents procedures in place.

The registered manager understood their legal responsibility around being open and honest with people when something goes wrong and notifying the Commission about significant events at the service.

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 17 April 2019)

Why we inspected

The inspection was prompted due to concerns received about infection prevention and control measures at the service. A decision was made for us to inspect and examine those risks.

We found evidence that the provider needs to make improvements. Therefore, we made the decision to widen the inspection to a focused inspection to review the key questions of safe and well-led. We carried out a second inspection visit. Please see the safe and well-led domain sections of this full report.

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

Enforcement

We issued a warning notice in relation to infection prevention and control. We identified breaches in relation to infection prevention and control, medicines management, assessing risk, staffing and the governance of the service. We made one recommendation about customer satisfaction surveys.

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 for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below.

Requires Improvement ●

148 Hornsey Lane

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.

We received information of concern about infection control and prevention measures at this service. We completed a targeted inspection looking at the infection control and prevention measures the provider had in place. We identified issues related to the infection control and prevention therefore we extended this inspection to a focused inspection. We looked at the safe and well led domain.

This inspection took place on 5 November and 20 November 2020 and was unannounced. We also communicated with the registered manager via online communication application throughout November 2020.

Inspection team

This inspection was carried out by two inspectors and one pharmacy inspector.

Service and service type

148 Hornsey Lane is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they 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

This inspection was unannounced.

What we did before the inspection

The provider did not complete the required Provider Information Return. This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make. We took this into account in making our judgements in this report.

We reviewed information we had received about the service since the last inspection.

During the inspection

During our visit, we spoke with two people who used the service. We also spoke with the registered manager, the Head of Service Disabilities, London and South Essex, one senior support worker and one staff member. We reviewed a range of records. This included five people's care records and multiple medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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 four relatives of people who used the service. We spoke with four professionals who know 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 good. At this inspection this key question has now 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.

Preventing and controlling infection

- We found that the provider was not keeping people safe because Infection prevention and control arrangements were not fully complied with.
- The provider's infection prevention and control policy was not up to date.
- The provider's infection prevention and control audit did not include guidelines and checks around the coronavirus pandemic.
- We were somewhat assured that the provider was using PPE effectively and safely. Staff wore PPE when providing support to people, however, they did not always dispose of used PPE as required by guidelines.
- We were somewhat assured that the provider was accessing testing for people using the service. People were offered COVID-19 testing and when they refused this was respected. However, there were no easily accessible records and monitoring system to ascertain what supportive action was taken and how often to encourage people to participate in COVID-19 testing.

We found no evidence that people had been harmed. However, sufficient systems were either not in place or robust enough to ensure people were fully protected from COVID-19 outbreak. 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.

- Following our first visit on 5 November 2020, the registered manager provided us with an action plan and evidence that the actions had commenced. During our visit on 20 November the service was in the process of making improvements to meet the warning notice we issued. COVID-19 signage was on display when entering the service. A new visitors' procedure was in operation and visitors were checked for COVID-19 symptoms. New automatic, non-touch hand sanitiser dispensers had been installed in each bathroom and toilet. We were also provided with updated Infection prevention and control policy.
- We were assured that the provider was accessing COVID-19 testing for staff.
- People were supported to reduce the risk of getting COVID-19 when going out into the community. Staff provided people with masks when they were going out and encourage them to wash their hands when they return to the service.

Assessing risk, safety monitoring and management

- Risk assessments were not always reflective of current risks faced by service users and the measures implemented to reduce this risk. One person suffered from several health issues. Their risk assessment did not specify what was the risk related to these conditions, how this could be reduced and what care staff needed to do in case the risk occurred.

- Staff were not always aware of risks to people's health and wellbeing. One person was advised to have thickened food and thin fluids. Staff were not aware of this when we spoke with them and did not have thickener in stock.
- We were not assured that fire safety measures were sufficient, including at night. The service carried out frequent fire drills to ensure people knew and followed the procedure in case of fire. Records showed that between three to seven people using the service had frequently not responded to the fire drill. One person had been responding, however, they did not go to the assigned assembly meeting point to wait for further support. There was only one staff member at night to support people. The provider could not assure us that in case of fire one staff member would be able to support people appropriately.
- People had a personal emergency evacuation plan (PEEP) to ensure they were supported appropriately in case of fire. In the case of one person, the provider could not assure us that support measures described in PEEPs for this person were in place.
- The provider carried out the service's fire risk assessment which highlighted shortfalls with fire safety measures. Although the provider had completed some fire safety works, as set out in the fire safety action plan, these had not been extensive enough. This was because they did not identify and act on issues highlighted by us during our inspection.

Risk assessment to health and wellbeing of people using the service was not robust enough and this placed people at risk of harm. This was a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Apart from the fire safety measures, health and safety of the building was maintained. The premises were free of clutter and environmental hazards. Health and safety checks included regular room checks and manager's monthly health and safety checks.

Using medicines safely

- The provider did not have a system for ensuring that all staff involved in medicines tasks were trained and assessed as competent. The registered manager was involved in assessing the ability of other members of staff to do medicines tasks, however, they did not provide evidence that they had received medicines training. Therefore, we were not assured that staff competencies in management of medicines were correctly assessed.
- Staff did not manage refused medicines doses in line with the provider's medicines policy. Staff were required to follow a specific recording procedure when people refused medicines. We did not see evidence that this procedure was followed.
- The provider did not have a system for ensuring the accuracy of information relating to medicines use and monitoring. This included recording, monitoring and information on medicines administered by visiting healthcare professionals. If a dose was late or missed, staff would not necessarily know how to act. This meant that people could have been at risk of their mental health suddenly deteriorating as a result of missed doses of specific types of medicine.
- The provider was unable to provide assurance that medicines were being stored in line with the manufacturer's recommendations. Staff said their medicines training did not cover the management of fridge temperatures where medicines were stored. We saw staff did not monitor and record temperatures of the fridge correctly.
- Whilst staff had protocols for most medicines taken when required (PRN), most of them had expired. For one person, there was no protocol for a medicine prescribed to treat anxiety.
- The provider's medicines policy did not always consider individual preferences in line with national guidance.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate medicines were always effectively managed. This put people at risk of harm. This was a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- The provider's staffing procedure was not always safe. Agency staff profiles were kept at the provider's head office and did not include the agency's staff photograph. Therefore, the managers at the service could not assure us that they checked that the authorised staff were working at the service.
- The provider could not assure us that agency staff working at the service had appropriate knowledge, experience and training to support people with mental health difficulties. We reviewed 12 profiles for agency staff working at the service. Nine out of the 12 did not state they had experience in supporting people with mental health difficulties. Mental health training had not been listed on any of 12 profiles we saw.
- The provider needed to review staffing levels at night. This was because having one member of staff wasn't enough to meet people's needs at night for emergencies including fire safety.

We found no evidence that people had been harmed. However, the lack of effective systems to ensure suitable and authorised staff were supporting people put people at risk of harm. This was a further breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We looked at recruitment records for two staff members, employed directly by the provider, who commenced their employment within the last 12 months. Recruitment checks, such as the previous employer and proof of identity, Disclosure and Barring checks (DBS) had been completed for the staff. The DBS helps employers make safer recruitment decisions and prevent the appointment of unsuitable people.

Systems and processes to safeguard people from the risk of abuse

- People felt safe at the service. One person told us, "I am very happy here. I like the staff." A family member told us, "My relative tells me they feel safe there."
- The provider had policies and procedures in place to safeguard people from abuse.
- Staff had training in safeguarding vulnerable people and they knew what action to take if they thought people were at risk of harm from others.
- A whistleblowing policy was in place and staff knew they could use it to raise any concerns.
- The managers took action when safeguarding concerns were raised. This included liaising with external health and social care professionals and investigating concerns to ensure people were protected from harm.

Learning lessons when things go wrong

- The provider had an accidents and incidents procedure in place. Staff understood what action to take when an accident or incident occurred. This included contacting emergency services, informing the manager and completing an accident and incident form.
- Accidents and incidents were recorded and then monitored for patterns or trends centrally by the provider. Records showed action had been taken to respond to occurring accidents and incidents and to reduce the risk of them happening again.

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 now 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; Continuous learning and improving care

- The overall managerial oversight of the service at the time of our inspection was not operating effectively. The service's team leader had been off work since August 2020. The registered manager, due to other managerial responsibilities, was present at the service only once a week. Managerial tasks and duties had not been delegated effectively to the senior staff acting up during the managers' absence.
- We found that the staff employed at the service and the agency did not have enough training and knowledge to work with people with enduring mental health difficulties. Records and feedback from external professionals indicated that staff had not always known how to support people in situations that may present a challenge.
- There were shortfalls related to managing and reducing the risk of harm to people. This was related to gaps in infection prevention and control, the management of medicines and risk assessment of the service delivery and people's health. We also identified shortfalls around the deployment of the agency staff.
- Quality assurance processes at the service were not effective and had failed to identify the matters we had found during the inspection.

The information above shows that systems were either not in place or robust enough to demonstrate that safety and the quality of the service delivery was effectively monitored and managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- After our initial visit on 5 November 2020, where shortcomings in infection prevention and control had been identified, managers took prompt action on improvements. These included improved infection prevention and control measures and the registered manager's visits increased from one to two days per week. We also noted that the team leader returned from long time leave and was regularly present at the service.
- Despite the above failings we saw some good examples of quality assurance systems used at the service. These included daily and weekly customer room cleaning schedule, daily shift planners and daily staff monitoring form for COVID-19.

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

- People were able to give feedback about their care and experience at the home. The service carried out a service users survey. The last one took place in June 2020 and 10 out of 12 people participated. The overall feedback was positive, however, some responses indicated people were not fully satisfied with aspects of the service. Six out of 10 people said staff were friendly and caring sometimes and four out of 10 said staff listened to what people wanted to say sometimes. We noted this aspect of the survey had not been analysed and actions on improvement had not been agreed.

We recommend that the service seeks further training and guidance on the effective use of service satisfaction surveys.

- People participated in monthly "house meetings" where they could discuss and choose what social activities they wanted and what food they would like to eat. People were also advised about various protective measures to help them to stay safe.
- Staff had regular team meetings to share important updates and guidance.
- The service worked closely with external health and social care professionals when needed. External professionals described the staff as caring. They also said the service would benefit from improved managerial oversight and additional training for staff on supporting people with enduring mental health difficulties.

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

- People and family members described staff as kind and caring. One family member told us, "Staff are nice, they are very patient with my relative."
- Overall, staff had supported people to keep in touch with their loved ones throughout the pandemic via socially distanced visits and telephone calls. However, one family member said that on one occasion a staff member did not share information about a person's wellbeing with them and the family member was unable to speak to the person on the phone on that occasion.

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 registered manager understood their responsibilities regarding the duty of candour.
- The registered manager had notified the Commission of significant events which had occurred which was required by the law.
- The rating from the last CQC inspection was displayed as required by the law.

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
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The registered person had not ensured care was provided in a safe way for service users because:</p> <p>They had not done all that was reasonably practical to assess and mitigate risks to care and treatment of people who used the service.</p> <p>Regulation 12 (2) (a) (b)</p> <p>They had not ensured the safe and proper management of medicines.</p> <p>Regulation 12 (2) (g)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The registered person had not operated effective systems to:</p> <p>Assess, monitor and improve the quality of the service.</p> <p>Regulation 17 (2) (a)</p> <p>Assess, monitor and mitigate the risks relating to health, safety and welfare of service users.</p> <p>Regulation 17 (2) (b)</p> <p>Maintain accurate records in respect of each person employed by the service. Regulation 17</p>

(2) (d) (i)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA RA Regulations 2014 Staffing

The registered person had not ensured sufficient number of suitably qualified, trained, competent and experienced staff enable them to carry out duties they are employed to perform.

18 (1) (2) (a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The registered person had not ensured care was provided in a safe way for service users because:</p> <p>They had not assessed the risk, and prevention, detecting and controlling the spread of, infections, including those that are health care associates.</p> <p>Regulation 12 (2) (h)</p>

The enforcement action we took:

We took enforcement action under regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We told the registered person to make the necessary improvements by 20 November 2020.