London Care Limited

London Care (Willow House)

Inspection report

Willow House
Victoria Court
Wembley
Middlesex
HA9 6EB

Date of inspection visit:
27 November 2017

Date of publication:
08 May 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We undertook an announced focused inspection of London Care (Willow House) on 27 November 2017. We inspected the service against three of the five questions we ask about services: is the service well led, is the service safe and is the service effective. We undertook this inspection to check that London care (Willow House) had followed their plan to improve the service after our inspection of 4 July 2017 and because we had received information about the death of a person who had lived at Willow House. .

No risks, concerns or significant improvement were identified in the remaining Key Questions through our on-going monitoring and during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

London Care (Willow House) provides care and support to older people and people with mental health needs living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. Willow House is a purpose built block of flats on 3 levels, containing 40 flats. People remain independent and live in their own flat within their community. 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. London Care (Willow House) provides personal care to 40 people living at Willow House via an individual contract with the host local authority. A separate provider manages the housing element of the service.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

We found that the arrangements to assess, monitor and improve the quality and safety of the service were not fully effective. The audit process had not identified some issues we saw such as absence of risk assessments and mental capacity assessments.

At our inspection of 4 July 2017 we had identified concerns about the safety of some of the people living at Willow House including whether the setting was suitable. At this inspection we discussed this with the provider at and after the inspection and we were provided with assurance that London Care (Willow House) was able to discuss such matters with the other partners and takes action as needed. However, we found that London Care (Willow house) needed to do more to work with others to address risks to people when they left Willow House. For example, we identified that five people using the service needed a high level of monitoring in relation to disorientation.

Some people at the service may have lacked capacity to make specific decisions but the service had not carried out mental capacity assessments. Some measures to protect people had been put in place if the

service had concerns about people leaving the premises unsupervised. However, there was no record in people's care records of whether or not people had capacity to agree to this. This was necessary to make sure if there was any form of restriction, this was done in a safe and correct way.

We have made a recommendation about the application of Mental Capacity Act 2005 in relation to people living in extra care housing.

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

Aspects of the service were not safe.

We found that some of the people using the service were at risk when they left Willow House. The provider needed to carry out more work with others to address this issue.

There were measures in place to prevent people from climbing through windows and falling from height.

People felt safe with the care workers.

Is the service effective?

Requires Improvement

The service was not effective.

Consent was not always sought in line with the principles of the Mental Capacity Act 2005 (MCA). Some people may have lacked capacity to make specific decisions but their mental capacity assessments had not been carried out.

Although it is the role of the local authority to raise matters of deprivation of liberty with the Court of Protection, Willow House had not submitted any application to the local authority to assess if the level of restrictions in place amounted to deprivation.

Is the service well-led?

Requires Improvement

Aspects of the service were not well-led.

This audit process was not effective because it did not identify some issues we saw such as absence of risk assessments and mental capacity assessments.

London Care (Willow House)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We carried out an unannounced comprehensive inspection of this service on 4 July 2017. At which a breach of legal requirements was found. This related to how the service managed risks to people.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. We undertook an announced focused inspection of Willow House on 27 November 2017 to check that they had followed their plan and to confirm that they now met legal requirements.

The inspection was also prompted in part by a notification of an incident following which a person using the service died. This incident could be subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk of people who required to be supervised when they were out in the community because of safety concerns.

The inspection team consisted of an adult social care inspector, a bank inspector, and an expert by experience. An expert by experience is someone who had personal experience with this type of service.

As part of the inspection process we looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including

serious injuries to people receiving care and any incidences that put people at risk of harm. We refer to these as notifications. We spoke with the local authority to see what information they held about the service. We also contacted the local authority for information they held about the service and reviewed the Healthwatch website, which provides information on care homes. This helped us to plan the inspection.

We spoke with seven relatives, the registered manager, the regional manager, seven care workers and a health care professional.

We also looked at records in relation to eight people to see how their care and treatment were planned and delivered. We looked at records relating to the management of the service, including a selection of the provider's policies and procedures.

Requires Improvement

Is the service safe?

Our findings

At our inspection in July 2017 we found that risks to people's health and safety were not safely managed.

At this inspection we saw that some improvements had been made. However, further improvements were required to address the risks we identified where people may wander out of Willow House.

We found that London Care (Willow House) did not always make sure that care planning arrangements to promote people's safety was coordinated with other agencies responsible for people's safety. The registered manager identified five people who had dementia. We looked at their care records, which stated they required a high level of monitoring in relation to disorientation and behaviours that challenged the service. Care workers told us these individuals were at risk of wandering out of the premises. Although the responsibility of people's safety was shared with others (landlords), the service had not effectively worked with others to ensure the safety and welfare of people. For example, care workers told us that the front door was easy to open and that people with dementia always attempted to leave. We were told that a few weeks prior to this inspection one person with dementia and at risk of wandering out of the premises went missing and brought back by the police. At this inspection care workers still raised concerns about the safety of the front door.

Although there were risk assessments and actions that staff took when they encountered risks we identified that there was a gap when it came to the situation where people may wander out of Willow House. Prior to this inspection, there had been an incident at the service. At this inspection we considered what the service had done to minimise similar incidents from happening again. We found that the service had not fully addressed similar risks presented to other people receiving care. In some examples, we saw that where risks had been identified, there were no risk management plans setting out how people would be supported. The registered manager advised us of the general measures that were in place to protect people. These included alert alarms on people's doors and a 24 hour electronic monitoring system. However, we did not find that these interventions were co-ordinated by all the agencies involved at Willow House and tailored to the specific needs of people. For example, one risk assessment identified that a person was at risk of wandering out of Willow House. The risk assessment showed that the person must have a mobile phone and a 24 hour monitoring system but they did not in practice. This failure to accurately assess and document specific individualised measures to minimise risks placed people at risk of harm.

These issues were bought to the attention of the registered manager who took immediate action to improve the risk assessments of people. The service has since submitted evidence to us showing they have updated all the risk assessments for people at risk. The registered manager told us all people now have a phone and a 24 hour monitoring system in place..

We asked seven people if they felt safe with the care workers and they were all content. Their comments included, "Yes, safe and happy", "Staff help me bath in the morning and apply cream. They are very helpful with me" and "I have no concerns, I am contented."

The registered manager had taken immediate action following our July 2017 inspection to address other matters by raising with the housing provider. In the last inspection, we found that windows in the communal areas on the first and second floors were wide open. They posed a risk of people climbing through them and falling from height. This was particularly important for people living with dementia and at risk of falls arising from disorientation or confused state of mind. At this inspection we found that window restrictors had been fitted. Therefore, the risk of people falling from height had been reduced.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in July 2017 we rated the provider as 'good' under the key question of 'Is the service effective?' However, following our inspection we received information of concern, which highlighted potential concerns about how people who may not have had mental capacity to make safe decisions were supported. At this inspection we found that the service was not working within the principles of the Mental Capacity Act 2005 (MCA).

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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). If a person's liberty needs to be deprived in other settings, an authorisation must be obtained from the Court of Protection.

We asked five people if care workers sought their consent before they provided care and support and they told us staff asked for permission before carrying out any care or support. Their comments included, "Yes, [staff ask for permission]. I also tell them what I want and they listen"; "[Staff ask for permission]. They always ask me"; "Yes, [staff ask for permission]. They ask before they help me with [personal care]." However, there were no records in people's care records to reflect how decisions about their care had been reached in their best interests. We noted from people's care plans that some had signed to have consented to their care even though their capacity to understand was in question. For example, decisions had been made in relation to the use of trackers and door sensors for people at risk of wandering out of the premises. However, there was no record the service had worked with others involved in people's care to ensure these measures were in people's best interests or whether or not people had capacity to agree to this. There was no record of a best interests discussions having taken place nor was there evidence these measures were the least restrictive in relation to MCA principles.

The registered manager and care workers advised us that some people had limited or no mental capacity. For example, one person had dementia. Their mental state was highlighted as 'confused at times'. Another person had dementia and short term memory loss. Their mental state was highlighted as, 'confused at all times'. Care workers told us at least five individuals were at risk of leaving Willow House unsupervised by staff. One care worker told us, "[This person] gets disoriented. She always heads to the front door, which is easy to open." Another care worker told us, "[This person] tends to head towards the door and if the door is open they will go." A third care worker told us, "[This person] says they want to go home to their children and grandchildren." Therefore, people were more inclined to leave Willow House if left unsupervised by staff.

Whilst we saw that some people moved freely within and outside Willow house, some were under restrictive practice. People with dementia were under close supervision. There were a number of liberty restricting

measures in place, including location devices; door sensors and verbal distraction techniques. The registered manager told us they could not stop anyone from leaving Willow House. However, we saw that steps were taken to prevent some people from leaving the premises, albeit this was done covertly. We asked the registered manager what would happen if a person showed a desire to leave Willow House and he told us, "We discourage them." This showed people could not leave the premises freely. We asked people what they thought about the service. One person told us, "It could be better organised. I would like to go out but I can't go out on my own." Another person said, "I get too claustrophobic."

Although it is the role of the local authority to raise matters of deprivation of liberty with the Court of Protection, London Care (Willow House) had not submitted any application to the local authority to assess if the level of restrictions amounted to deprivation. Therefore, there was a risk people could be deprived of their liberty unlawfully.

We recommend that the service carries out discussions with other agencies involved in the care of people at Willow House to make sure that care for people who are unable to give consent is carried out in accordance with the MCA 2005.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in July 2017, we identified a breach in regulation regarding how Willow House was managed and the well-led domain was rated as 'requires improvement.' This was because the provider did not effectively assess, monitor and improve the quality and safety of the service provided. At this inspection we found improvements were still required.

People were placed at Willow House via the host local authority. We found that Willow House may not have been appropriate for some people as their needs could not be fully met. Whilst we saw that Willow House was meeting the needs of most people, they were not equipped to meet the needs of people who required a secure environment or those who may be at risk if they left Willow House unsupervised for their safety by staff. A care worker told us they did not think Willow House was, "right for some [service users].

Prior to this inspection there had been an incident at the service, which highlighted potential concerns about support of people who required a secure environment. The CQC was notified by the registered manager that some people had been moved from Willow house because London care (Willow House) could not meet their individual needs. Care workers told us a person had left the premises unsupervised by staff despite this being unsafe for them due to dementia. This person was seen by another person using the service near a main road. Eventually they were supported by the police to return to Willow House safely.

Although we found that Willow House had made improvements in some areas since our last inspection, we still identified other matters that the provider's audits had not identified. We identified that Willow House had not carried out person centred risk assessments for people that were at risk of leaving Willow House. This was also true of mental capacity assessments for people, who may not have had capacity to make specific decisions. This showed the audit process was not effective because these matters were not identified.

There was evidence to show that Willow House had taken some action to address the matter regarding admissions of people with higher needs. The registered manager and the team leader advised us that Willow House was 'now rejecting some referrals'. We saw that a recent referral of someone who was known to be at risk of wandering had been rejected.

People found the registered manager to be helpful. The registered manager could tell us knowledgeably about the support each person was receiving. We found him to be familiar with important operational aspects of the service, as did the team leader of the service. The registered manager acknowledged the need to balance people's safety with maintaining their independence. Since this inspection the registered manager has reviewed the care of all people at Willow House and some people have been referred for mental capacity assessments.

We asked people what they thought of the registered manager and they described him in complimentary terms, including, "He tries his best"; "The manager is approachable" and "The manager is alright. I can see him anytime I want to." Care workers were equally complimentary. They felt supported by the registered

manager. One care worker told us, "My manager is very good." Another care worker said, "He is a very good manager. He listens to us."

There was an open and inclusive approach to running the service. There were regular meetings to enable people, their relatives and staff to share ideas and discuss any relevant issues. There was partnership work with other organisations and the local authority to ensure they followed and shared best practice. We saw evidence that Willow House has been working with the local authority to improve standards in the light of recent incidents.

We noted that a system for managing accidents and incidents was being developed. We identified that a few accidents had been recorded but these had not been analysed for the purpose of identifying trends and learning.