Three C's Support

Three C's Support - 71-73 Dunton Road

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 27 August 2015 and was unannounced. Three C's Support - 71-73 Dunton Road is a care home that provides accommodation and support for up to seven people, who live with mental ill health. At the time of the inspection there were seven people using the service.

There was no registered manager in post as at the time of our inspection. 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.

At our previous inspection on 25 February 2014 the service had met the regulations we inspected. At this inspection we found that the service was in breach of five regulations.

Summary of findings

Staff had not acted promptly to report two allegations of abuse to the local authority safeguarding team.

Staff were supported by the provider to carry out their caring roles. Training needs were identified and discussed in supervision and in their annual appraisal. We found that the effectiveness of staff training was not assessed. We have made a recommendation about the effectiveness of staff training.

Consent to received care was not always sought by staff. The provider was not aware of their responsibilities within the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). People and their relatives were not always involved in assessments about their mental capacity, when this need had been identified.

People were not provided with planned activities carried out in the home. People were not able to make a choice in the meals they had, because there was not a menu that they could choose from. We also found expired food in the fridge.

People did not have access to healthcare when needed or to maintain their health. Assessments were not always updated to identify or manage their changing needs. The service did not identify and manage risks associated with people smoking in their bedrooms and communal living areas. we made a recommendation about involving people in decisions about their care.

The provider monitored the service and carried out quality audits; however, these did not identify areas of concern we found or make improvements to ensure people received consistent quality care. The was no clear management accountability or overall responsibility of the service.

People were provided with information on how they could make a complaint and how this would be managed.

Incidents and accidents which occurred at the service were reported and managed appropriately. Medicines were managed safely and people received them to manage their health needs.

People were treated with respect and dignity by staff, and people we spoke with confirmed this. There were sufficient staff to meet some the needs of people they cared for.

We are considering the action we take and will publish an updated inspection report in the future.

Summary of findings

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 safe. People were at risk of receiving unsafe care because assessments were not always updated or accurate.

Staff were aware of signs of abuse but did not act promptly to raise an allegation of abuse to the local authority.

People received their medicines safely.

There were sufficient staff to meet people's care needs appropriately.

Is the service effective?

Requires improvement

The service was not effective. Staff received an appraisal, training and supervision; however the effectiveness of the training was not assessed.

The provider was not aware of how to support people in line with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards.

People did not have access to healthcare services when required.

Is the service caring?

Requires improvement

The service was not always caring. People were not supported to make decisions regarding their care.

People were treated with dignity and respect by staff.

People of their relatives did not have the opportunity to contribute to assessments and reviews of their care.

Is the service responsive?

Requires improvement

The service was not responsive. People and their families were not supported to contribute to their care assessments.

People were not supported with their changing care needs.

People were able to raise a complaint with staff and they were confident that their complaint would be managed and resolved.

Is the service well-led?

Requires improvement

The service was not well-led.

The quality of care was monitored, but did not identify areas of concern we found.

There was no registered manager in post.

There was no clear management and accountability of the service to meet the needs of people of staff.

Three C's Support - 71-73 Dunton Road

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.

This inspection took place on 27 August 2015 and was unannounced. It was carried out by an inspector, a pharmacist 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.

Before the inspection we reviewed information we held about the service and what we received from the local authority and the local health authority. We received information from the local authority and the London Fire Brigade fire safety officers, regarding the fire safety at the service. During our visit we spoke with three people who use the service, one visitor and four members of staff. We reviewed seven people's records and their medicine administration records and other records relating to the maintenance and management of the home.

Requires improvement

Is the service safe?

Our findings

People did not always receive a service which was safe and met their needs. One person told us, "I am safe, I look after myself." A visitor commented, "Yes, I feel that my friend is safe." These comments did not reflect what we found during the inspection.

People were not protected from the risk of harm. The provider had not protected people against the risk from harm, because the provider had not taken actions to appropriately identify and act on allegations of abuse. During the inspection we found that a person was at risk of abuse. We spoke with staff about two incidents, where a person was at risk of financial abuse. The incidents referred to money mismanagement and an allegation of fraud. The person's care records did not have details of the allegations of financial abuse. There was no safeguarding adults' referral to local authority for investigation. After the inspection we made two safeguarding referrals to the local authority safeguarding team and they were investigating our concerns.

People's risk assessments were not always up to date. People's identified risks were not managed appropriately, therefore, increasing the risk of them receiving unsafe care and support. For example, the risk assessment for a person with swallowing difficulties did not identify detailed actions for staff to follow to reduce risks for them from choking. People were at risk of unsafe care because the provider had not developed appropriate guidance for staff to reduce risks. Staff did not respond to people's changing care needs or the way in which they delivered care and support to them. For example, we saw one person whose ability to breathe had deteriorated. Staff told us that their breathing had deteriorated in the last six months. Staff had not sought advice from health care professionals to meet the changing need. People were at risk of deterioration in their health because staff had not assessed, reviewed and monitored people's changing needs.

People's medicines were not correctly recorded. People's medicine administration records (MAR) were supplied by the pharmacy printed with all the necessary details of each medicine. MAR were signed to show that medicines had been given as prescribed and where medicines were refused this was recorded. However, we saw that where medicines were provided by the hospital these had to be added to the MAR. Staff had done this by writing the medicine name and instructions. We saw that some of the details had been incorrectly transcribed, for example the strength of one medicine was written as 500mg in 1ml instead of 500mg in 5ml which had been supplied. The person had been receiving the correct dose, but the record was inaccurate, increasing the risk of drug errors which could impact on the health and well-being of people.

People were at risk of the effects of fire. People were allowed to smoke in their bedrooms and we saw evidence of cigarette ash in overfilled ashtrays or on the floor. However, people did not have personal fire risk assessments in place and there were no fire risk assessments for the communal smoking room. We discussed smoking at the service with staff. We checked five care records of people which smoked in their rooms. There were no personal evacuation plans in place for people in case of a fire. Fire risk assessments had been recently carried out by the London Fire Brigade and the local authority fire safety officers did not find any areas of immediate concern. The health of people living in the service and staff had not been taken into consideration, and they were at risk of fire and health complications due to people smoking in the service.

At the time of writing this report the provider was aware that there were fire safety concerns and there was a review of smoking at the service by provider. People were being supported to understand those risks and maintain a safe environment. Recent house meetings took place to discuss fire safety with all people living at the service.

These issues were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's bedrooms were decorated in accordance to their wishes; each room was individually decorated with personal items such as photographs of their family.

The environment was in a poor state of maintenance with peeling paint internally. We found a chair that was broken, we informed a member of staff because they had not noticed this. The member of staff had told us that they would arrange for the chair to be removed. The person was at risk from injury because they continued sitting in the chair. The furniture in the communal are was worn in places. We observed light bulbs on the ground and first floors which were not working. We looked in the stored cupboard and found a number of lightbulbs which could

Requires improvement

Is the service safe?

replace them. The provider had not ensured that people lived in an environment which was well maintained. There was a communal telephone for people's use which was not working; people told us that they used the phone in the office. This limited people's privacy and the ability to use the telephone as they wished.

These issues were a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People received their medicines safely. We observed medicines being given to one person in a safe and caring manner. The medicines were taken to the person in the lounge, where they preferred to have them. We were able to check the stocks of medicine and found that the records for ordering medicines were accurate. Medicines that were for disposal were returned to the dispensing chemist and records for this were provided.

People were cared for by enough staff to meet their needs. There were sufficient numbers of staff who provided care and support for people. The staff rota showed that there was a mix of skilled workers on each shift. For example, there was a senior care worker who supported care workers during each shift. However, we found that some people were not supported to access the community as they wished. We asked staff whether a person would be supported to go out, we were told that this would not be possible as there were insufficient staff to support the person in this way.

The provider ensured that suitably qualified staff were employed and references and criminal records checks were carried out before the staff started working with people at the service.

Incidents and accidents were recorded. We found that staff had recorded incidents and accidents which occurred at the home or when outdoors, and appropriate actions were taken to reduce the risk of the incident recurring.

Requires improvement

Is the service effective?

Our findings

People were at risk of eating food which did not meet food safety standards which was a risk to people's health. We checked the food available to people and noted a number of food items were out of date and others did not have a date on them when they were opened. People were at risk of consuming expired food. We checked the fridge in the dining room and found pastries which had expired. We asked staff how food safety standards were maintained at the service.

Staff did not demonstrate an understanding of the people's nutritional needs to manage their health conditions. For example, a referral was made to a dietician for a person with swallowing difficulties. The dietician had recommended a specialist diet for this person. Staff told us the person ate the same diet as other people. The person's dietary requirements were not met. This person did not have access to meals which met their nutritional needs, increasing the risk of choking, swallowing difficulties and deterioration of health. The provider had not protected people against the risk of poor nutrition and hydration. People had access to food and drink throughout the day, and were able to prepare themselves a meal or drink, independently or with support from staff when required.

These issues were in breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not act on the advice of health professionals to ensure that people were supported safely. For example, a person was at risk of complications from their medical condition. They required specialist support for their foot care. We found that staff had not adhered to the professional recommendation of the person attending foot care appointments every three months. We found another example where a health professional who recommended additional support for a person with their mental health was not followed by staff. Another example we found was the dietician had provided guidance for staff to provide appropriate meals for a person to reduce the risk of choking. Staff we spoke with were unaware of these risks for the person. Staff did not follow the professional recommendation in place, increasing the risk of deterioration in health. This increased the risk of unsafe care increasing the risks of poor health.

These issues was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could not be confident that they were cared for by staff that were skilled and knowledgeable to meet their needs appropriately. Staff had completed training in fire safety, moving & handling and food safety. There were no clear processes in place on how the effectiveness of staff training was assessed. We identified that staff had not applied their learning to their work because we found areas for concern with their practices in the areas of management of medicines, fire safety and food safety. For example, MAR were not always correctly completed, people did not have personal fire risk assessments completed and there was no process to ensure the food in the fridge was checked.

We recommend that the service finds out how to assess the effectiveness of training provided to staff based on best practice guidance.

The provider did not have an understanding of their role and responsibilities in line with the requirements of Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). One member of staff told us, "At least two people here are not allowed out on their own, we have to go out with them at all times." A recommendation made from a health professionals in March 2015, identified the need for a mental capacity assessment, best interests decision and a DoLS application to be made to safeguard a person. We checked their care records and these assessments had not been completed. The provider did not have an understanding of their responsibility the requirements within the Mental Capacity Act in general, and (where relevant) the specific requirements of the DoLS. People could not be confident that the provider would be able to protect them from the risks from the unlawful deprivation of their liberties.

Consent was not always obtained from people and the provider did not follow the correct process to ensure people were not unlawfully deprived. People were not routinely asked for their consent to receive care and support from staff. The records we looked at confirmed this. One person told us, "I do the care myself, staff don't ask me anything." During our observations staff did not seek consent when providing care and support to them.

Requires improvement

Is the service effective?

People were not supported to make decisions where needed. Staff had not always involved people and their relatives in making decisions. For example, we saw reviews of care were completed by staff without the input from the person or their relative. People were not encouraged to contribute to their care and support needs.

These issues were a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were supported by the provider to carry out their caring roles. Training needs were identified and discussed in supervision and in their annual appraisal. Staff completed mandatory training, such as basic life support and medicine management, records showed these were completed in 2015 and was up to date. One member of staff told us, “We get medication training. Fire training. We do health and safety and food hygiene training as well.” The previous registered manager had conducted supervisions every four to six weeks and annual appraisals were completed. Staff told us that they worked together as a team to provide care and support to people.

People said they enjoyed the meals provided for them at the service. People living at the service prepared meals for themselves and other people at lunch times. We asked staff about the arrangements for meals, we were told that people help staff prepare and cook meals for themselves and other people living at the service as a part of their daily living activity. We observed one person going out to the supermarket to purchase items to prepare their lunch, without supervision.

Requires improvement

Is the service caring?

Our findings

People did not always receive a caring service. Assessments were completed with people before coming to live at the service. These were completed in order for staff to assess whether they could meet people's care and support needs.

People or their relatives did not have the opportunity to make decisions in planning their own care. After people came to live at the service, assessments were completed by staff with no reference to discussions with the person or their family. Care plan reviews we looked at had not been signed by the person or their relative to demonstrate they understood the care and support choices offered to them. Staff told us that they had involved people in their care. People we spoke with told us that they were not involved in developing their care plans or made decisions in their care and how they wished to be cared for.

We recommend that the service seek guidance from a reputable source, about supporting people to express their views and involving them in decisions about their care, treatment and support.

People were treated with dignity and respect. We observed interactions between staff and people in the lounge and dining room areas. It was clear from the chatter that people were relaxed in their environment. Staff approached people in a caring manner and knew people's individual preferences and respected their dignity. For example, we observed staff manage a person's query promptly.

Staff acted promptly to relieve distress. We observed that two people were having an argument at the service. This took place in the communal lounge area. We observed staff went to calm the situation down in an attempt to resolve the concerns people had. Staff spoke with both people and calmly and appropriately asked them for their view of their reasons the argument between them began. The member of staff acted appropriately, resolved the issues, dissolved the argument and resolved their concerns.

People were supported and encouraged to maintain relationships with people outside of the home. Relatives were encouraged to visit when they wished. People had regular contact with their relatives and people that mattered to them. One person told us, "My friend visits every week to see me." We observed friends visiting people at the service; they were greeted and made to feel welcomed by staff. Relatives were encouraged to participate in birthday celebrations and meals at the service.

People's care records were stored securely in a locked room and staff had access to them when needed. Staff were aware of the need of confidentiality when managing people's care records and keeping their personal private information safe.

Requires improvement

Is the service responsive?

Our findings

People did not receive a service which was responsive to their needs. People or their relatives were not involved in making decisions, or contribute to the assessment and planning of their care. Assessments were completed by staff. People's needs and wishes were not used to develop care and support which met their requirements or needs. People's strengths and abilities were not obtained, increasingly the likelihood of them receiving inappropriate care.

Staff did not respond to people's health care needs promptly. For example, the GP requested that a person have regular blood tests. Regular blood tests results were used by the GP to determine whether a change in their treatment was required. The person did not have the tests and staff could not describe how to support the person with their health condition, increasing the risk of deterioration in their health. Another person had a particular physical condition that required the use of medicines to relieve the symptoms. This person's care plan did not refer to the need to use these medicines. Staff we spoke with were unable to explain why this information was missing. People could not be confident that they would be supported to have treatment as prescribed, increasing risk to their health.

We looked at the care records for a person with diabetes and swallowing difficulties and mental ill health. Their care records did not state what treatment or support was provided to the person to identify and manage those conditions safely. People with medical conditions were not assessed or their support implemented appropriately, increasing the risk of deterioration of people's health, due to a lack of monitoring and support of their health care needs.

These issues were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not encouraged to participate in social activities which interested them. During our discussions with people we identified that they had various interests and hobbies that they had before coming to live in the home. One person told us, "If I feel bored, I just go and sleep in my [expletive] bed." Another person told us, "I don't like anything here." We spoke with staff about the activities available for people and they told us that two people attended daycentre up to three days a week. There were no activities provided for people in the home, increasing the risk of isolation for people. Some people had to rely on staff to take them out of the home due to identified risks associated with road safety. However, we found that those people who required support with outdoor activities were not supported to do so. When we discussed this with staff they told us that there were not enough staff to take them out. People were at risk of isolation because they were unable to leave the service without assistance which limited the activities they could participate in.

This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Friends and relatives were encouraged to come to the home. For example, one visitor told us they visited their friend regularly and was able to visit as they wished.

People and their relatives were provided a copy of the complaints form, which people could complete with support. The complaints policy and procedure was available for people, relatives and staff. Staff told us that the complaints procedure was easy to follow. There were no current complaints about the service or about the care people received.

People were supported to complete certain tasks during the day. This included assistance with meal preparation and maintaining a tidy bedroom. Staff told us these tasks were a part of people's therapy to help them develop daily living skills.

Requires improvement

Is the service well-led?

Our findings

People did not always receive a service that was well-led. A registered manager was not managing the service at the time of our inspection there was no clear management of the service.

The registered manager had left the service in July 2015, staff confirmed this. A project leader was appointed to the service. However, there were no clear management arrangements in place at the service on the day of our inspection. The person identified to be the registered manager worked from the provider's head office and not at the service. People were at risk of receiving care which did not meet their needs as the overall management and accountability of the service was not clear.

There were no effective quality assurance systems in place. During the inspection we asked to see information on how the service monitors and reviews the quality of service provided to people. Staff were unable to provide this information to us as they were unaware how this was completed. After the inspection we requested information from the provider to demonstrate how the service identifies, monitors and reviews the quality of care. We were told that we would be provided with this information; we have not received this at the time of writing this report. We found areas of concerns regarding fire safety, risk assessments, access to health care and medicine administration records, which had not been identified by the provider. People who lived at the service and received care could not be confident that the quality of care they received was of a good standard. The provider failed to implement a process to ensure that people received good quality care which met their needs.

A customer satisfaction survey was carried out in 2014. People did not receive a quality service because the provider had not analysed the results which applied to the service. Therefore the provider was unable to appropriately monitor the quality of service or take action to improve care provided to people.

We were told that there were no processes in place to monitor and dispose of expired food. One member of staff told us, "sometimes the night staff check the fridge when they complete the fridge temperature checks." We asked to look at the log of temperature checks and we noted that these had been accurately recorded.

The service carried out fire drills, however records showed that these were not carried out on a regularly basis. The last recorded fire alarm test was in June 2015. The provider had not identified risks associated with people smoking in the home or protected people in the event of a fire. This increased the risk to people's health and well-being.

These issues were in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People who use services were not protected against the risks associated with unsafe care.** **Regulation 9 (3) (a) (b)-(h).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People who use services were not treated with dignity and respect.** **Regulation 10.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **People who use the service did not always have their consent sought by staff.** **Regulation 11**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People did not have access to healthcare when their needs changed. Increasing the risk of the deterioration in their health and well-being.**

This section is primarily information for the provider

Action we have told the provider to take

Regulation 12 (f) & (g) (2) (i).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People who use services were not provided with appropriate nutrition. People did not have access to meals which met their health and medical needs. Regulation 14.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who used services were at risk of inappropriate or unsafe care and treatment. The provider did not regularly assess and monitor the quality of the service. People who use service were at risk of poor care because their records were not updated, accurate or met people's needs. Regulation 17(2)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People were at risk of unsafe care because the provider did not assess the effectiveness of staff training so they could meet people's needs. Regulation 18 (1).