London Care Limited

London Care (Ensham House)

Inspection report

Franciscan Road
London
SW17 8HE

Date of inspection visit:
09 May 2018

Date of publication:
04 July 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We inspected London Care [Ensham House] on 09 May 2018. This was an unannounced inspection.

At our previous inspection on 17 & 24 August 2017 we found the provider was not meeting regulations in relation to the outcomes we inspected and we issued a warning notice in relation to Good Governance. At this inspection, we found the provider had met the breaches we found at the previous inspection.

At the last inspection, the service was rated Requires Improvement.

At this inspection, the service was rated Good.

London Care [Ensham House] provides personal care and support to people living in an extra care housing scheme. This consists of 45 individual flats within a staffed building with some communal areas. At the time of our inspection there were 43 people using the service. A separate organisation manages the building. Not everyone using London Care [Ensham House] receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

There was a registered manager at the service. 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.

The registered manager was relatively new and had been in post since January 2018. People using the service, relatives and staff were positive about the impact he had and the improvements he had made since he had started. This include changes to the allocation of staff on their daily shifts which they felt were more responsive to people's needs.

People told us they felt safe living at the service and that care workers were kind and caring towards them. People received appropriate support in relation to their medicines. They told us they felt supported in relation to their health and nutritional support needs. However, a common theme in our conversations with people were that care workers were rushed and did not support them much above and beyond the basic level of care.

People lived independent lives and any restrictions in place were in line with the Mental Capacity Act 2005, in their best interests.

Staff told us that their rotas had improved and there were enough staff to support people. They spoke positively about the training and supervision they received. The training covered areas of care that were deemed mandatory and supervision was based around staff performance and in areas relevant to their roles

such as medicines.

The provider had robust recruitment checks in place and carried out appropriate checks to ensure suitable staff were employed. At the time of the inspection, there were upcoming changes being considered for the makeup of the senior team within the service.

An assessment of care needs was completed before people came to use the service which looked at the risks to people and how they could be made safe. Care and support plans included goals and outcomes that people wished to achieve and how people could support and assist them to achieve their goals.

Records such as complaints, incident and accident monitoring and medicine administering records were completed appropriately.

The provider had an appropriate system in place to check the quality and safety of the service people received. The regional manager undertook periodic audits that included general information and focussed on a specific topic, such as medicines or people's personal care and support records. We saw that the overall compliance scores were improving as each audit was undertaken.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service had improved to Good.

Risk assessments were carried out before people began to use the service.

People told us that they felt safe. Care workers received safeguarding training and were aware of reporting procedures.

The provider had robust recruitment checks in place. We received mixed feedback from people in relation to timeliness of care workers, however the registered manager had tried to make improvements in this area.

Care workers supported people to take their medicines.

Is the service effective?

Good

The service had improved to Good.

Care workers received mandatory and thereafter received regular ongoing supervision.

People's consent to their care and support was taken.

People were supported with regards to their health and nutritional needs.

Is the service caring?

Good

The service remained Good.

Is the service responsive?

Good

The service had improved to Good.

Complaints received were recorded appropriately and records showed they had been acted upon.

Care plans were developed in collaboration with people.

Is the service well-led?

Requires Improvement

The service had improved to Requires Improvement.

The provider demonstrated they acted upon feedback received via quality assurance checks.

People, relatives and staff were hopeful that the new registered manager would have a positive impact on the delivery of the service.

London Care (Ensham 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 inspected the service on 09 May 2018. The inspection was carried out by two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses a domiciliary care service.

We reviewed information we held about the provider, in particular notifications about incidents, accidents, safeguarding matters and any deaths. An expert by experience spoke with four people who used the service and five relatives to gather their views about the service provided. We also spoke with five care workers, the manager and the care coordinator.

During the inspection we spoke with 10 people who attended a coffee morning. After the inspection, an expert-by-experience spoke with two people using the service and seven relatives. We also spoke with the registered manager, one team leader and two care workers.

We reviewed a range of documents and records including; five care records for people who used the service, four staff records, as well as complaints and compliments records and policies and procedures kept by the service.

Good

Is the service safe?

Our findings

At our previous inspection which took place on 17 & 24 August 2017, we found that appropriate medicines records were not always kept. This included not signing Medicine Administration Record [MAR] charts when medicines were administered and signing them when medicines had not been administered. We also found the provider did not always accurately record incidents that occurred.

At this inspection, we found improvements had been made. The provider was now meeting the regulations.

People and their relatives confirmed they were happy with the support they received with regards to their medicines. They said, "If they didn't remind me I wouldn't take my medicines", "[Relative] has two visits a day and really that is for medications, which is all fine", "The medicines seem to be OK", "The medicines seem to be alright" and "[Relative] needs eye drops and cream daily and it has been running out and I have spoken to them about that but the other medicines seem to be OK."

We reviewed MAR charts for people and these were completed appropriately. Where there were gaps, these had been identified in the weekly audits completed by the team leaders. People were able to self-medicate if they were happy to do so, risk assessments were completed for people that needed medicines support and the level of support needed, whether prompting or administration. Training records showed that care workers had received training in medicines support, either for those that administered medicines or medicines awareness for staff who didn't administer medicines. Staff also received regular themed supervision in safe medicines practice.

Incidents and accidents were recorded on paper and uploaded onto the online reporting system called Branch Reporting System [BRS], the records for these were compete showing details of the incident, the action taken and any follow up action. The paper records and the BRS records correlated. A relative said "It has been good this last year and we have only had two incidents and they [staff] have responded really quickly, they have run upstairs and got the Ambulance and everything, so I am happy."

There were enough staff employed to meet people's needs safely and in a timely manner. However, comments from people and relatives indicated there were still some concerns with how quickly care workers attended to people's needs.

People and their relatives said, "Timekeeping is OK, if I call the alarm they generally turn up in good time" "Everything is fine, they do come on time but not necessarily the times I want, I do know most of them but it's been a bit changeable recently", "My main worry is the amount of different carers. They have three calls a day and it can be three different carers in the day and a different set the next day. They are often new and [relative] has to tell them what to do", "It's worse at weekends, it's always new ones then", "[Relative] gets concerned that lots of different carers come, he is supposed to get at least one carer that knows him, that's on his care plan but that doesn't happen and he gets upset at that" and "The morning call is for 8am but it's anywhere between 7 and 9 am, which is a long time to wait for a drink really."

Staff told us, "Staffing issues are the main issue – carers are rostered on shift then they call and cancel at the last minute. We need more reliable staff! For the last few months though it's not been bad, not bad at all" and "We can't hold on to the good, reliable staff. I wish we could find people to stay for a long time who are reliable and don't cancel at the last minute."

The registered manager had recently introduced a system whereby staff were allocated to visit specific people at specific times. Staff told us this was an improvement to the previous system, and one care worker said, "It's a lot better now, we know where we are meant to be and when. It's a much fairer system." We saw that the allocation system noted when people required assistance from two care workers and when their support must be provided at a specific time to ensure they received time-critical medicines appropriately. One person said, "I think they were short staffed, it was worse but hopefully it's getting better."

Staff commented that this new system was an improvement on the previous system of allocation. They said, "Since the allocations have changed, it's been so much better" and "The main issue here is the staffing, people not turning up for their shifts. We do cover for each other and pull together as you can't cut corners in care, you have to provide the support that people need - but it is stressful when people don't turn up. Things have got better since [the registered manager] started and started allocating the shifts."

We reviewed staff rotas for the two months prior to our inspection, and saw that staffing ratios were determined based on people's needs. For example, there were fewer staff on duty when people were staying in hospital rather than at the service. We also saw that people who had been assessed as requiring one-to-one support, for their own and for others' safety, were provided with this and these staff were not included in the general staffing allocation on the rota.

The provider followed the principles of safer recruitment. We looked at four staff personnel files and saw that each included a record of an Enhanced Disclosure and Barring Service check to check that the staff member was not barred from working with adults in need of support, two references that had been verified with the referee, an application form detailing their experience working in health or social care and proof of the staff member's right to work in the UK.

People using the service told us they felt safe. Relatives also told us they had no concerns. Comments included, "I'm happy, I feel safe in my flat", "I feel safer here than at home", "I am sure they are safe there", "[Relative] is safe with them, it relieves any worries I have", I think [relative] is safe, it's just the rushing which can't be nice" and "Yes [relative] is safe but I am having to get a key safe fitted as [relative] can't answer the door and the district nurse can't get in."

Care workers were aware of reporting procedures if they had any concerns. One care worker said, "I am very confident that the manager knows what to do. I have reported concerns before, and they were looked into and reported on straight away, and acted upon. I have also reported issues myself to the local authority and been part of safeguarding investigations." Records showed that care workers received safeguarding training. Records showed that when safeguarding concerns had been raised, these were documented appropriately and the safeguarding team contacted to carry out investigations. The registered manager was aware of the safeguarding procedures in place for the service which included contacting the safeguarding team, submitting a notification to the CQC, creating a safeguarding record and informing the providers regional manager.

The care co-ordinator carried out a 'needs and risk assessment' when they received a referral. This included assessing people's level of independence and support needs in relation to a number of areas including communication, medication, personal hygiene, dietary needs and maintaining the home environment. Any

potential risks/hazards in relation to each of the assessed areas and how they could be mitigated by care workers were included. Risk assessments were reviewed regularly to ensure people continued to be safe and staff were able to meet their needs.

A falls/mobilising risk assessment was in place to assess the level of risk in relation to falls. This include steps that staff needed to take to keep people safe. A person said, "I'm prone to falling, but I have this [call button] around my neck and it makes me feel safe." Other risks assessed were in relation to personal care, nutrition, skin care and medicines. An environmental risk assessment was also completed. Where there were specific risks for people, based on previous behaviours there were appropriate assessments in place. For example, where there was a risk of absconding guidelines gave staff instructions on what steps to take and who to contact.

The service managed the control and prevention of infection. Staff received training in infection control. Relatives said, "There are gloves and aprons in the flat but I have to say I've never seen them with an apron on", "They wear their gloves and aprons" and "The cleanliness seems to have improved recently."

Good

Is the service effective?

Our findings

We spoke with the registered manager regarding the process for referrals, he told us they would receive a copy of an assessment from the referring body and based on that and conversations with the referring person a decision would be made if people were suitable for a placement. The registered manager said they carried out their own assessment and family or friends often advocated for people during this process. If everyone agreed, arrangements would be made for people and their families to come and view their flat and relevant contracts would be signed. In the care records that we saw, assessment forms were in place showing that people were assessed before moving into the service.

New staff received an appropriate induction before they started work. Records showed that staff underwent training in topics that the provider considered mandatory, such as safeguarding adults, care and welfare of people who use the service, safe working, moving and handling, infection control and food hygiene. After the training, staff then underwent a period of 'shadowing' a more experienced staff member. We noted that an assessor observed the staff member and assessed their competency on a range of topics before they were able to work on their own with people who use the service. A care worker said, "I have nearly finished my NVQ3, which London Care have given me time to do. They didn't pay for it [it was funded] but they arranged it and gave me the time I needed to complete." Another said, "Training is OK and we get regular supervision."

Staff were appropriately supported through ongoing training, appraisal and supervision. After their initial induction training, records showed that staff attended training on a range of topics, some specific to the needs of the people they supported such as stoma care and diabetes awareness. The provider had developed a range of training resources to highlight the impact of staff work on the care people received. For example, we saw a training workbook relating to reducing the risk of choking that was titled 'Impact and consequences of getting things wrong' and related to Cathy Smith, a fictional person "who deserves good care". This personalised the training and ensured staff were aware of the consequences of their work.

Records showed that staff had regular supervision meetings with their line manager to discuss their work, as well as annual appraisals. Some of the supervision meetings highlighted a specific topic for the staff member to address and test their knowledge, such as medicines management and record keeping. Staff members' ongoing competency in these areas were assessed as part of these 'themed supervisions'.

Where there were concerns about a staff member's performance at work, we saw these had been addressed through appropriate supervisions and training, and we also that the provider had a disciplinary procedure in place that was effectively used to address and improve performance.

The provider also facilitated staff gaining qualifications appropriate to their work, such as the Diploma in Health and Social Care to level two and three.

We saw evidence of collaborative working with external stakeholders. For example, correspondence from community teams when people had been referred for specialist support. For one person, advice was sought

from the maximising independence team when staff needed some support around specific moving and handling techniques.

The Mental Capacity Act 2005 [MCA] provides a legal framework for making particular decisions on behalf of people who use the service and 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. We checked whether the service was working within the principles of the MCA.

People's consent was obtained and they were given a copy of their care and support plans when they first began to use the service, they were also involved in care plan reviews.

Care plans included a section for important personal information such as details of power of attorney [POA] and details of people's consent in relation to access records, access to rooms and restraint. There was also a section about how people could be supported to make decisions and if they had capacity to do so. There was section in relation to any memory difficulties and how they made decisions. Where people were not able to make decisions, there was evidence that these were taken in their best interests with input from relatives, friends or other significant people in their lives.

Training records showed that care workers had received training in understanding their responsibilities under the MCA.

People and their relatives said that care workers looked after their general health. Comments included, "The GP comes regularly, you put your name down in a book", "[Relative] gets visits from the district nurses and things and I am going to ask the manager about going to the dentist."

Care plans contained evidence of health appointments that people had attended and referrals that had been made in relation to people's health. People's current medical conditions, medical history and a list of current medicines were recorded so that both staff and health professionals were aware of them or if they needed to be contacted.

People and their relatives told us the support they received in relation to their dietary needs could be better. Many of the negative comments were in relation to the perceived lack of time they felt that staff had. They said, "They won't do fresh veg or anything like that, they don't have time", "The food isn't heated properly as staff are rushing, some of it is cold." One relative said, "The meals are a bit of an issue, I prepare meals and put them in the freezer for them to microwave, they won't use the cooker only the microwave. Take the shepherd's pie I made, they just turn it out upside down in a mess on the plate and it puts [my relative] off eating it, it's just simple things really." Another relative said, "My bugbear is the food. So much food goes out of date or I find them giving [my relative] food from the fridge which has gone out of date. I found [my relative] eating a corned beef sandwich that was two days old. I have left notes all over the fridge and freezer but it makes no difference, no one seems to look." Other people and their relatives said the food support was satisfactory, "They do all the meals and that seems ok", "I do a big shop every two weeks and they prepare it" and "My [family member] goes shopping for me."

People lived in individual flats with their own bedrooms, open plan kitchen and lounge and bathroom. They were able to decorate and furnish their flats to their liking. They also had access to a large communal space and lounge on the ground floor where they could meet with family and friends if they chose to do so. There was an outside space that was well maintained and used to host a coffee morning on the day of the

inspection.

Good

Is the service caring?

Our findings

People using the service told us they were treated with kindness and were positive about the caring attitude of the care workers. Comments included, "They are very nice to me, very polite", "They are caring and friendly, very respectful" and "They make me laugh." Relatives were also positive about the attitude of care workers, telling us "[Relative] was very depressed but they look after her", "They [care workers] are very nice", "They are nice to [relative], she would tell me if they weren't", "Some of the carers are worth their weight in gold but others just don't bother", "There is one who will put on music and sing and chat to [relative]", "[Relative] says the girls are really nice, they have settled in really well and seem to enjoy living there" and "[Relative] seems happy enough and not upset about anything."

There were some negative comments in relation to staff support which were attributed to staff not having enough time, these included "Some carers are really good but some aren't so good but I think that is the rushing element of it" and "The staff are really nice but it is just that they are so rushed."

We observed some lovely caring interactions between staff and people who use the service. We saw that one person was becoming distressed, however staff responded appropriately, spoke softly to the person to support them to calm down, redirected them and gently led them away from the group where their behaviour was starting to distress others.

A care worker said, "People are very friendly and looked after very well. There are some challenging behaviours but I have been trained and know what to do. I was shouted at yesterday, but I just stayed calm and redirected [the person] and I wasn't scared." Another care worker said, "I do enjoy working here. We are like their family. I'm used to the people and their needs."

Care plans included a section that included people's life stories, things that were important to them and their lives. This meant that the service could provide care and support in a way that was person centred and according to people's preferences. Care records captured key information about people including any personal, cultural and religious beliefs. This allowed care workers to be aware of people's diverse needs and so that care could be provided that meant their human rights were respected.

People said their privacy and dignity was respected. One person said, "They don't come in without knocking." The living arrangements, with people living in individual flats meant that personal care could be carried out in privacy according to how people wished to be supported.

People were supported to express their views and were involved in making decisions about their care and support and treatment. People and if appropriate, their relatives were involved during the initial assessment and also during care plan reviews. People also lived independent lives, and were supported to maintain relationships that were important to them. Comments included, "I spend time downstairs in the evening chatting with the other people, I like it" and "This is more independent, I'm able to go out by myself."

Good

Is the service responsive?

Our findings

At our previous inspection which took place on 17 & 24 August 2017, we found records kept in relation to complaints were not always completed appropriately. For example, investigation reports were not complete and other records not clear if they had been resolved to the satisfaction of the complainant.

At this inspection, we found improvements had been made. The provider was now meeting the regulation.

The provider had a system in place to receive, respond and act upon complaints. The registered manager retained a log of complaints received and we saw that four complaints had been received in 2018. Each complaint was investigated using an 'investigation report' including appropriate evidence such as statements from the staff and people involved in the complaint. We saw that action was taken as a result of complaints, for example one person complained that the door to their flat was too heavy for them to open so the registered manager arranged for their door to be replaced with a lighter version. We saw that three of the four complaints had been satisfactorily resolved and one was ongoing at the time of our visit.

Care plans were developed in collaboration with people, and where appropriate with their relatives and health and social care professionals. An assessment of people's needs was completed before people started to use the service and care and support plans were developed using this information. Care and support plans included goals and outcomes that people wished to achieve and how people could support and assist them to achieve their goals. Care plans also included a section relating to how people communicated and how staff could support them if they had difficulties communicating verbally.

Care workers also completed daily care needs with details of the personal care and other tasks they supported people with. Care plans contained evidence of regular quality assurance visits taking place to ensure that people continued to be happy with the service received and their records were up to date.

There were limited communal activities on offer for people. There was a regular coffee morning, and one was taking place during our inspection. This was well attended with 10 people in attendance. Apart from this there were film nights and a communal lunch on Fridays.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection which took place on 17 & 24 August 2017, we found quality assurance checks were not effective in picking up concerns. Although these checks were in place, we found that the provider did not always act upon the feedback or the action points identified.

At this inspection, we found improvements had been made. The provider was now meeting the regulation.

The provider had an appropriate system in place to check the quality and safety of the service people received. We saw that the regional manager undertook periodic audits that included general information and focussed on a specific topic, such as medicines or people's personal care and support records. We saw that actions from these audits had been undertaken, for example the February 2018 audit noted that a staff member had not been trained in a specific topic, and we saw in their training records that this had been completed by the time of our visit. Each of the audits resulted in an overall compliance score for the service, and an action plan with specific actions, dates for completion and person responsible for the action noted. We saw that the overall compliance scores were improving as each audit was undertaken.

There was a registered manager at the service who had been in post since January 2018. 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 and associated Regulations about how the service is run.

Both relatives and staff felt that the registered manager had implemented some positive changes since he had started. Relatives said, "I am very happy with it", "I do have to say that things have improved since [managers name] came. I think this one will get things done by the look of it, well I hope so", "He seems better than the last one but we shall have to see", "I have met the manager, he seems alright and things have improved a lot really since he came, but I do think the maintenance of the building could be better, but we are happy with it all told."

Comments from care workers included, "This is generally a very nice place to work", "The changes the registered manager has implemented have been very positive."

People who used the service were also able to contribute their ideas through 'resident meetings', however we saw that the most recent of these took place in June 2017 and people had raised similar issues to those recorded in the meeting for March 2017, indicating that they weren't addressed. A relative said "We go to the House meetings but I have never seen any minutes to those."

Staff were able to contribute their ideas for the service through quarterly staff meetings that were quite well-attended by care staff, however we saw that the agenda for these was standardised for all services run by the provider and the section at the end was specific for London Care (Ensham House) was blank for each of the records we looked at.

We recommend the registered manager reviews the mechanisms used in the service for seeking feedback from people and staff, to ensure that feedback is appropriately sought, recorded and acted upon.

The registered manager was not responsible for recruitment of staff, which was highly unusual. Instead, staff were recruited and interviewed through the main branch office and then sent to the service for shadowing which was the first time the registered manager met them. We spoke with the registered manager about this and highlighted that as the registered manager, he was legally responsible for the staff employed but yet had limited say in their recruitment.

There had been some changes in the leadership team at the service. At the time of the inspection, the scheme manager had left and out of the three team leaders, one was on long term sick and one had recently left, leaving the team with only the registered manager and one team leader. The registered manager said that the plan was not to have a scheme manager in future but to employ a care co-ordinator to work alongside him. They were also planning on having two care coordinators instead of three in future.

We recommend the registered managers reviews the impact these changes may have on the provision of staffing, in light of the comments received from people and relatives regarding the timeliness of staff.

The service worked with external stakeholders and agencies to support the care provided to people. We saw evidence of the provider corresponding with health and social care professionals to help ensure joined-up care, for example with social services.