London Care Limited

London Care (Bristol Court)

Inspection report

Bristol Court
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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**

Summary of findings

Overall summary

About the service
London Care (Bristol Court) is an extra care scheme which opened in 2019. This is purpose-built accommodation which has 94 flats in total comprising of one and two bedrooms. There were 12 homes which provided specialist dementia support and 15 homes providing specialist support for people with a learning disability. Assisted living (also known as extra-care housing) is a type of 'housing with care' which means you retain independence while you're assisted with tasks such as washing, dressing, going to the toilet or taking medication.

People's experience of using this service and what we found
Medicines were not always administered safely. Risk management plans were not always in place when a specific risk had been identified. Risk management plans are plans which provide care workers with guidance as to how they could reduce possible risks. The provider did not have clear systems in place for dealing with infection control practices.

The provider had systems in place to record accidents and incidents, but we were not able to see evidence of the learning being embedded into the service. The provider did not always have safe recruitment practices in place.

People were assessed prior to moving into the service. Care plans did not always record important information to guide care workers to respond to people's needs.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People's dignity and privacy was not always maintained and at times people felt their care was rushed. People did not always know who was going to provide their care and support. However, people enjoyed living at the service and relatives felt their loved ones received good care.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. People told us they were not always told when their care workers were running late. The care people received was not always person centred and people wanted to participate in more activities. When people raised concerns and complaints, they were not always responded to in line with the providers policy.

There were systems in place to monitor the quality of the service and identify when improvements were required. These were not sufficiently robust to have identified the issues we found during the inspection.

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

Rating at last inspection
This service was registered with us on 12 September 2019 and this was the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding and management of medicines. A decision was made for us to inspect and examine the service.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We identified breaches of five of the Health and Social Care Act (Regulated Activities) Regulations 2014 relating to safe care and treatment, person-centred care, dignity and respect, manging complaints and concerns and good governance. Please see the 'action we have told the provider to take' section towards the end of the 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below

London Care (Bristol Court)

Detailed findings

Background to this inspection

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

Inspection team
The inspection team included two inspectors and a member of the CQC medicines team.

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

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
We gave the service 24 hours' notice of the inspection. This was because we needed to be sure that the registered manager would be in the office to support the inspection.

What we did before the inspection
Before the inspection we looked at all the information we held about the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with the registered manager, quality compliance manager, one team manager, one senior care worker and four care workers. Following the inspection, the Expert by Experience contacted 10 people who were using the service and received feedback from five people. We reviewed a range of records which included medicine administration records, and risk assessments for eight people. We looked at five people's care plans. We looked at six staff files in relation to recruitment and supervision. We also reviewed a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence we found. We contacted 30 staff who worked for the service and received feedback from 11. We also sought feedback from a range of professionals who support people at the service, and we received feedback from six professionals.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. This key question has been rated 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.

Using medicines safely

●Medicines were not always being managed safely. We reviewed eight people's Medicine Administration Records (MAR). Five of the eight people whose MARs we reviewed had been prescribed medicines for pain or constipation to be given daily on a regular basis. However, staff members had incorrectly changed the instructions for these medicines on MARs to be given as when required. This meant people were not being given these medicines as prescribed to manage their pain and prevent constipation.

●Time sensitive medicines were not always given as prescribed. For one person who was prescribed a medicine to be given on an empty stomach, at least 30 minutes before breakfast (or another oral medicine) to prevent osteoporosis, the staff had not given this medicine as per the prescriber's instructions on two out of four occasions during a month. This meant the medicines may not have the desired effect. Osteoporosis is a bone disease that occurs when the body loses too much bone, makes too little bone, or both.

●The MARs used by the provider were not completed as per the provider's own medicine policy. The policy stated that it was not acceptable for labels pre-printed by a pharmacist to be added to the MARs. However, most MARs found in use at the service had medicine labels from pharmacy stuck on MARs for prescribed medicines.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to ensure the safe management of medicines. 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.

●There were gaps in some people's MARs. Gaps in the MARs signify the care workers had not given the medicines during these times. However, these had been identified during the provider's audits and raised with care workers responsible for giving medicines.

● Care workers we contacted confirmed they had completed the appropriate training regarding medicines.

● After the inspection we were told the local Clinical Commissioning Group (CCG) pharmacy team would be assisting the provider with matters relating to the medicines policy and practice.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

● Risks to people had not always been considered, assessed or planned for to help ensure people received care safely. Where risk assessments were in place, they were not always detailed enough. For example, one person had conditions affecting their legs, which required care workers to know about the potential risks and to monitor for signs of deterioration. This person's risk assessment made no reference to these health conditions, so care workers did not have accurate information to appropriately mitigate the possible risks

associated with this condition.
● In other people's files we found some information was conflicting or incomplete and placed people at risk of harm as care workers might not have the necessary information to keep people safe. For example, one person had a history of falls and this was detailed in their referral paperwork from the local authority. This person had two falls since they moved into the service, but their falls risk assessment stated they were at low risk of falls. We raised this with the registered manager who said this person's risk assessment had not been updated correctly.
● People's care plans had recorded other possible risks such as drinking alcohol to excess. However, where this was recorded in one person's care plan, there were no assessments of the risks associated with this and no information for care workers on how to support this person in a safe way.
● We did not always see evidence of clear processes in place from learning when incidents and accidents occurred. For example, we read in one person's daily logs a care worker had found a tablet in their bed. We could see no information recorded about this in the incidents and accident folder.
● In other cases where there were incidents of a serious nature there was often very little information recorded so we were unable to see what action the provider had taken to mitigate any further risks. The provider's paperwork for recording incidents and accidents had sections called "Corrective and preventive action and follow up and resolution" but when we reviewed this paperwork, these sections were often left blank. We didn't see evidence of the learning from incidents being embedded into the service to improve the care and support people received.
● When we reviewed all of the safeguarding incidents since the service opened, we found there were gaps in the information recorded. This meant we could not be assured the provider was learning lessons from the outcome of the safeguarding investigations.

This was a further breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The registered manager recognised there were gaps in how they were recording information. They showed us evidence of weekly meetings with managers where they were discussing people and their support plans and identifying action that needed to be taken to ensure people's care plans were updated correctly.

Preventing and controlling infection
●During our inspection we read two people had raised concerns in July and September 2020 about care workers not wearing personal protective equipment (PPE) correctly. We could see no action taken by the registered manager to address these concerns. During the inspection people also told us they were concerned as care workers did not wear their mask correctly. One person told us, "No not always. They wear gloves and aprons, but one didn't wear a mask and others don't wear masks properly and don't cover their noses".
● We observed care workers and management were not always wearing their mask correctly. This told us the provider did not understand their responsibilities for maintaining standards of infection control as care workers had access to protective equipment such as masks, disposable gloves and aprons.

This was a further breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●We raised this with the registered manager, and they assured us they would ensure all staff wore PPE correctly.
●Since the inspection the registered manager has sent us evidence of improved practices for manging infection control practices.

Staffing and recruitment

●The provider did not always communicate when care workers were running late. Four out of the five people felt they were not informed when care workers were running late. One person told us on one occasion their night-time call came at 1.15am instead of 11.00pm. We discussed staffing with the registered manager, and they told us, "We will discuss and agree with the service user, the times of their calls, this will be based on what they want, their needs (i.e. medicines) and the capacity of the service."

● We spoke with seven relatives and some felt call times was an issue when the service opened but things had improved since the registered manager had started. The registered manager recognised call times had been a challenge since the service opened and they were trying to address the issues people faced. This was further impacted during the pandemic. To achieve this, care workers were now being allocated to specific areas of the service to work in. The registered manager felt people's experience would improve as they would know which care worker to expect. We spoke with one senior carer who told us the calls were now been planned in advance and if carers were running late, they contact a senior carer and they would cover the call. These changes have only started recently, and they are still trying to embed the new procedure.

● The registered manager told us call times were monitored when they reviewed people's communication logs, but they recognised the importance of having a specific system to monitor people's call. The provider is planning to introduce a new system next year. We will look at this when we next inspect.

● New staff were not always recruited safely. We reviewed 6 staff recruitment files. The provider's policy stated references must be from their last employer in health and social care, however when we reviewed two care workers files their references were not in line with this policy.

● In another file we identified there were gaps in two staff member's employment history. A record of staff members' full employment history is a legal requirement. The provider's quality assurance team had identified the issues we found when they recently carried out an audit.

● The provider took prompt action on the day of the inspection to address the issues we found with recruitment.

Systems and processes to safeguard people from the risk of abuse

● The provider had policies in place providing clear guidance on how to respond to allegations of abuse.

● Care workers completed training on safeguarding adults as part of their mandatory training and the care workers demonstrated a good understanding of the principles of safeguarding and how to contact the local authority if they had concerns.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet
● People's care plans identified what support people required to prepare their meals, however they were not always sufficiently detailed. For example, in one person's file we saw there was advice from a GP for the person to "Aim for high calorie and high protein meals" yet there was no information in this person's care plan regarding the advice given by the GP.
● In another person's support file we read they needed support with nutrition and hydration, we checked their food diary and observations sheet and it was blank except for their name.

The lack of person-centred care plans placed people at an increased risk of not having their needs met. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's care plans included information on how care workers could support them with making and eating food and drinks.

Ensuring consent to care and treatment in line with law and "
The Mental Capacity Act 2005 (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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Overall the provider had a process for identifying and supporting people who lacked mental capacity. We

looked at four people's support plans and there were clear systems in place to ensure people were being supported within the principles of the MCA. However, in one person's file it was recorded they had "variable capacity." There was no other information and no explanation of what "variable" meant. We saw no evidence of the provider completing best interest or mental capacity assessments for this person.

● Some people had signed their own consent forms, whilst other family members who had authorisation had signed forms on people's behalf. When relatives had signed, it was because they had the legal authority to do so and there was evidence of this in people's files.

● Care workers had received training on the MCA and we found they understood the principles. One care worker told us they always sought people's consent before supporting them with personal care. Comments included, "The MCA in practice is assuming people have capacity unless it is deemed otherwise" and "Someone with dementia may not be able to decide if they should have a medical procedure completed, but they may be able to tell you if they would like cornflakes or porridge".

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support.

● Before the pandemic the service had a dedicated GP surgery visiting the service but since the pandemic consultations were completed on line. Relatives raised concerns that health professionals were still not coming to the service. s They felt those who were vulnerable might be at risk of their health deteriorating as they were not receiving face to face consultations. We raised this as part of our feedback with the local authority and they told us they would look into this further.

● The provider had worked with other agencies including healthcare professionals to meet people's needs. People told us that care workers had supported them to access health care professionals. One person commented, "Yes, they have gone above and beyond".

● Within the provider's support plan there was space to record the level of support people required with their oral hygiene. People confirmed they were supported to ensure their oral healthcare was addressed. In one person's file we read, "Carer to place toothbrush and hand it to me".

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs were assessed prior to accessing the service. The housing referrals were managed by the local authority and people were assessed by social workers who worked for the borough. These assessments were then shared with the service. The assessments we saw were sufficiently detailed to provide a picture of a person's needs, their risks and their capabilities.

● Senior care staff met people before they moved into the home as they visited them to carry out their own assessment. People were also encouraged to visit the scheme with their relatives/representatives and meet people who lived at the service.

Staff support: induction, training, skills and experience

● On the whole people and their relatives felt care workers had the required training to complete their roles. However, feedback from professionals commented that care workers did not have specialist training for supporting people who were living with dementia or those who had a learning disability. During the inspection, we spoke with the registered manager about specialist training and they told us people had dementia training, however we received feedback from some care workers who told us they would welcome more formal training in this area.

● Care workers completed a range of training and had regular supervision from their line manager. Senior care workers also carried out spot-checks to ensure care workers had the required skills to do their job.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- We found the service was not always caring and at times did not always ensure people were treated well as we identified some concerns with the way the service was providing care and support to people. We asked people if they felt safe and one person told us, "Yes and no. I do feel safe when they are washing and dressing me but not with my night call time and some carers being bossy unnerves me." This person also raised concerns about their door not always being locked properly. This told us, at times, people felt they were not receiving good care and support.
- When we looked at people's files, we were not able to see what support was given to meet people's nutrition and hydration needs. This meant we were not always able to see if people were being supported safely.
- The provider did not always have detailed risk assessments in place to help keep people safe. Information which was important to people was not always recorded within the provider's care plans which meant care workers did not have up to date information relating to people's physical health needs.
- During the inspection we read that two people felt their privacy and dignity was not respected and people told us that care workers did not always respect their homes. One person told us, "No. [They] don't clean up properly and show little respect for it".
- We asked care workers how they ensured people's dignity and privacy was maintained, comments included, "I handle their needs with care and ensure they are aware and comfortable with what I am doing" and [I] give him choices and personal centred care by keeping his information private".
- People had mixed views when asked if they were supported to be independent, One person told us, "Yes I am quite capable about decisions in relation to how I want my care done but unfortunately some carers as already discussed, can be bossy and tell me what they are going to do. I don't like to argue so sometimes don't and let them get on with it. Not a perfect situation" and "I try to stay independent myself but need help with washing and walking is difficult, but they do this and help me get about, so I suppose the answer is yes". This told us that some care workers were not providing care in a person-centred way.

The provider had not ensured that people were always treated with dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We also received some positive feedback. Comments included, "Very happy. Carers are so helpful, very

nice and polite and I love having them look after me" and "[Care workers] always ask me if they can do anything else before they go so caring". Relatives told us they felt they were involved in the care of their family member and were kept well informed by management.

●Relatives we spoke with felt staff treated their love ones with dignity and respect when they received care and care workers supported people to remain independent. Comments included, "I feel the care is really good, it is amazing for him. His wellbeing is so amazing" and "My [relative] is happy, and they do care and they do look after her."

● The registered manager told us they used themed supervisions sessions as a way to highlight the importance of treating people with kindness and compassion. They told us, "We always ask care workers would you let your sibling move in here, and that is the starting point for us". The registered manager also confirmed care workers would be receiving further training in specialist areas such as supporting people who had a learning disability. We will look at this when we next inspect.

● The registered manager knew how to support people to access advocacy services if required, however at the time of inspection no one was offered this service. The registered manager said this was a priority and they were working with the learning disabilities manager to move this forward. Advocacy services offer trained professionals who support, enable and empower people to speak up.

● The registered manager told us they were keen to support people to become more independent and they were working with each person to look at how best to achieve this, for example they were supporting one person to have travel training so they would be able to attend college independently. The provider had also recently recruited a dedicated manager working to support people who live in the dementia and learning disability flats.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- The culture at the service was not always person-centred. Care workers did not always provide care in a way which was safe and reflected people's personal preferences. People's care plans were not always updated when their needs changed. For example, one person's care plan showed a healthcare specialist had requested a more tailored care plan was required to support the person to reduce the risk of behaviours that could challenge. This action had not been completed.
- We did not see a coordinated system to review care packages when people's needs changed. For example, one person needed to use a standing aid for 45 minutes each day, but care workers were not supporting this person with this task, as the call time was 30 minutes.
- Care plans did not always record information about people's cultural background. We read in one-person's file, care workers did not respect their culture and beliefs. We saw no actions taken by the registered manager to identify what the specific concerns were and to try and address the issues raised. This placed people at an increased risk of not having their needs are met.

This was a further breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We did however see evidence of personalisation in care plans relating to people's background. This included information about people's backgrounds, where they worked, their families, what was important to them and their likes and dislikes. For example, we read people enjoyed doing IT, gardening and cooking. One care worker told us having this information was helpful to get to know people.
- Care plans were written in the first person and provided care workers with information on what can cause anxiety, worry or fear and how this can be managed.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The provider was not implementing the AIS standard. There were people who did not speak or read English as a first language and the registered manager had not ensured information was provided to these people in a format they easily understood.
- We read in one person's care plan that they had a visual impairment but there was no other information to tell care workers how best to support this person. We asked the registered manager if policies relating to people's care and support were written in an easy read format and they told us this was not currently

available.
● Where one person did not speak English as their first language, we read care workers notes which recorded they were not able to speak to this person. We could not see if the provider had done anything to support this person or to try and seek specialist support.
● We discussed with the registered manager if they used communication cards as tools to engage with people and they told us they did for one person, but we checked this person's support plan and we found no reference to communication cards being used. This demonstrated that care plans were not updated with important information relating to their care and support.

This was a further breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● The provider did not have robust arrangements to ensure complaints were appropriately investigated, responded to and resolved. When we reviewed the complaints folder, we could see the registered manager was not responding to people's complaints in line with their procedures.
● One person raised 2 complaints about their care but did not receive an appropriate response in line with the provider's policy, another person made a complaint about their care for which we did not find evidence of an investigation.
● In another case, we found a relative had made a complaint on behalf of someone living at the service which was not responded to in accordance with the complaints policy.

The fact that complaints were not responded to appropriately by the provider was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● People and their relatives told us they were supported to maintain relationships which were important. Throughout the pandemic relatives told us that they were supported by care workers to facetime their loved ones. The registered manager explained if people did not have access to IT, they would lend them the necessary equipment. The registered manager told us activities had stopped as a result of the pandemic, but they were trying to start group activities as they recognised the importance of this.
● We received feedback from one professional who raised concerns about people not having social stimulation. It was recognised that the pandemic has had an impact but there was concern as "People tend to stay in their rooms and can feel very isolated not being able to maintain relationships with their families, especially during the lockdown".
● Before the pandemic the provider was working with key partners to develop specialist activities for people with dementia and learning disabilities. . Although this had been stopped the provider was exploring how it could start again, to ensure people have access to specialist activities.
● One care manager told us they encouraged people to access activities which were available online and people were open to participating in these.

End of life care and support
● Since the service opened there had been two deaths but care records did not record people's end of life's wishes and preferences. We raised this with the registered manager as part of our feedback and they recognised the need to record people's wishes in relation to end of life care.
● We received feedback from two stakeholders who told us the registered manager had handled a recent death with dignity and respect. Comments included, "The ethos was around care and what the client

needed. and "The care for the [person] was beautiful to witness ".

● The registered manager confirmed after the inspection that they would be ensuring people's end of life's wishes were recorded in their care plan.

Requires Improvement

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.

This is the first inspection for this newly registered service. This key question has been rated 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;

- The registered provider could demonstrate that they had undertaken some quality audits and they were starting to address shortfalls.
- However there was a lack of oversight and monitoring of the service and as a result they did not identify risks relating to managing medicines, caring for people, recruitment of staff and there was a lack of understanding of delivering person centred care and ensuring people were treated with dignity and respect. This meant people were at risk of potential harm.
- During the inspection we noted there was a lack of information recorded. Notes and actions from meetings were either poorly recorded or not recorded at all. This meant there was a possibility actions would not be completed which could have a direct effect on people using the service.
- People did not always know when care workers would turn up and despite their many requests people did not have regular carers.
- Opportunities were missed to use quality assurance feedback for driving improvements. When we reviewed quality assurance monitoring records, we could see key issues that the same people faced, but we could see no confirmation of what the provider was doing to improve people's overall experience of living at the service. A common theme was care givers running late. We discussed the quality assurance audits with the registered manager who told us, "If people say no, they are not happy we should be drilling down and sorting it out". The provider was not monitoring call times so people did not feel their concerns were appropriately addressed.
- People did not always feel they were communicated with effectively. People told us when they called the service sometimes, they did not receive a response. We received similar feedback from a stakeholder who identified this as a concern, but said there had been improvements since the registered manager started.
- The registered manager recognised they needed to review how they audited quality assurance feedback to ensure the provider could take prompt action to address people's concerns.
- When complaints and concerns were raised they were not always acknowledged or responded to in line with the provider's policy.
- The culture at the service was not always person-centred. Care workers did not have the information they needed to care for people in a way which was safe, reflected their preferences or met their needs. Whilst care plans had been audited, the process had not identified the issues we found during the inspection and there was no system in place to check that they contained all relevant and important information relating to people's ongoing care and support.

The lack of appropriate governance arrangements and effective quality assurance processes meant that the provider could not demonstrate they were providing a safe, quality and consistent service to people. 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.

● People and their relatives told us they felt the management team was generally visible around the service and were approachable.
● Since the inspection the provider assured us they have been working closely with the local authority to address the issues we found during our inspection.

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.
●As part of the inspection we spoke with the registered manager about their understanding of their responsibilities under the duty of candour and the provider demonstrated they understood their responsibilities. Under the Duty of Candour providers have a legal obligation to be open and transparent and must follow specific guidelines f things go wrong with care and treatment. However they had not investigated or responded to complaints.
Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The registered manager and senior staff had started to hold meetings with people to gain their feedback and views. They told us these had stopped because of COVID- 19 but they were trying to restart them again. One person told us, "Yes. I had a meeting with the big boss only yesterday about my care, hurrying me, going early and not cleaning properly."
● Since the service opened there has been three registered managers in post, the most recent one starting in May 2020. Staff and care workers on the whole felt that management team was approachable but sometimes they felt they would welcome more time to discuss the day to day issues they were facing.

Working in partnership with others
● The service had been operating for a year and the provider was continuing to develop partnerships. The registered manager was working in partnership with healthcare professionals and local authority colleagues to drive ongoing improvements.
● We saw evidence of involvement from external professionals such as physiotherapists GPS, district nurses and dieticians.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not always ensure people received care which met their needs and preferences. Regulation 9 (1)

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not always ensure people were treated with dignity and respect. Regulation 10 (1) (3)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always ensures safe care and treatment because they had not always assessed risks to service users safety nor had they done all that was reasonably practicable to mitigate the risks to the safety of service users. The provider did not always ensure the proper and safe management of medicines. Regulation 12 (1) (2)

Regulated activity	Regulation

Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider could not demonstrate that the service was responding to people's complaints according to their complaints process. Regulation 16 (1) (2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not always operating effective systems and processes to assess, monitor and improve the quality and safety of the service and to assess, monitor and mitigate risks Regulation 17 (1) (2)