Care UK Community Partnerships Ltd

Lennox House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This focused inspection was carried out due to concerns that had arisen since our previous inspection which suggested that a person using the service was placing themselves and other people at risk by their behaviours.

This inspection took place on 5 and 9 August 2016 and was unannounced. This inspection was carried out by two inspectors and an inspection manager. This report only covers our findings in relation to the specific concerns that were raised and our findings are reported under safe and well- led in this report. You can read the reports from our last comprehensive and focused inspections of the service by selecting the 'all reports' link for Lennox House on our website at www.cqc.org.uk

Lennox House provides accommodation for up to up to 87 older people, some of whom also suffer with dementia. On the day of the inspection there were 82 people residing at the home. The home is divided over four floors. On the ground floor intermediate care is provided for a maximum of twelve people. Residential care for people using the service who do not require nursing care is provided on the first floor. Nursing care is provided on the other two floors.

There was a registered manager in post. 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.

On 5 July 2016 CQC attended a meeting with Islington Social Services Department. We were informed of an alleged incident of abuse that had occurred in March 2016. Islington Social Services Department had not been informed of the safeguarding concern until 6 May 2016 and CQC had not been alerted via a statutory or other notification by the provider. At this focused inspection, we found that the service had not properly considered the risk posed by a client to others or taken sufficient steps to monitor that risk or respond to it. This meant that some people at the home had faced unnecessary risks to their safety and wellbeing.

The service had failed to notify CQC of the alleged serious incident of abuse in March 2016, as they were required to do by the regulations. We found that the manager of the home had not followed the provider's procedures for notifying incidents and responding to them. The provider was aware of the incident by at least 9 May 2016 when they met with the local authority to discuss it, but no notification to CQC had subsequently been made.

As a result of this inspection we found that the provider was in breach of Regulations 12 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 of the CQC Registration Regulations 2009.

Full information about CQC's regulatory response to any concerns found during inspections is added to

reports after any representations and appeals have been concluded.

You can see what action we told the provider to take at the back of the full version of the report.

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. The procedure for reporting concerns was not always followed. An alleged serious safeguarding incident and another six alleged safeguarding concerns were not dealt with appropriately which put people at significant risk of harm.

Risks assessments did not always reflect the nature of the risk. Risk assessments were not always reviewed or updated when risks changed. In relation to one person's risk assessment, this placed people at significant risk of harm.

Is the service well-led?

Requires Improvement

The service was not always well-led. Procedures for communication between managers, care staff and local authority safeguarding and CQC were not operating correctly.

Incidents that require notification to other agencies, for example the local authority safeguarding team and CQC were not always reported or responded to in the appropriate way. Organisational protocols for monitoring incident trends and action required were not effective as the incident trends had not been identified.

Lennox 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 checked 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 undertook an unannounced focused inspection of Lennox House on 5 and 9 August 2016. This inspection was carried out as a result of serious concerns reported to CQC by the local authority.

We inspected the service against two of the five questions we ask about services: is the service Safe and Well-Led. This is because it was reported that the service was not meeting legal requirements in some of the key lines of enquiry on both of these outcome areas. The inspection was carried out by two inspectors and an inspection manager.

Prior to the inspection we checked information that had been supplied to us by the local authority safeguarding team. We looked at notifications the provider had sent us that are required by law under the Health and Social Care Act 2008. During the inspection we looked in detail at records relating to three peoples using the service such as care planning and risk assessments. We looked at other records such as accident / incident reports, safeguarding and notification policies and staff rota. During our inspection we spoke with the registered manager, acting operations manager, two care assistants, two unit managers and three registered nurses.

Requires Improvement

Is the service safe?

Our findings

At this inspection, we focused on how the home was managing the risks a person living at the home presented to other people and how staff and the home had responded to any incidents that had occurred.

The service had access to the provider organisation's policy and procedure for protection of people from abuse. They also had the contact details of the London Borough of Islington, the authority in which the service is located and which mostly placed people at the service. The provider organisation's procedure for responding to concerns of abuse set out the policy in line with common national and locally agreed procedures. The policy stated that any concerns of abuse should be reported without delay to the relevant authorities, including CQC. Care and nursing staff we spoke with were clear about reporting any concerns to the senior member of staff on duty.

When we spoke with staff about what they were required to do if they had concerns or were aware of incidents, they were clear about reporting this to a more senior manager and either recording events on care records or in the accident and incident records. The provider's policy states that all accidents / incidents must be reported to the senior member of staff on duty and a record on the accident / incident must be made. There had been a number of incidents involving one person living at the home which posed a risk to other people living at the home.

An alleged incident occurred in late August 2015 which had not been reported to the previous manager until mid-September 2015. Once it had been reported, a safeguarding alert was made and the police were informed. CQC was notified about the alleged incident. An investigation took place and the placing authority put one to one support in place at night for the person whose behaviour was posing a risk to other people using the service. This one to one support involved sitting outside the person's room so that should they try and leave their room at night and potentially go into other people's bedrooms, staff could intervene. On examination of the staff rota for this period between September and December 2015 we found that one to one cover was not indicated on the rota on 22, 23, 24, 29, 30 September 2015 and 12 to 18 October 2015. The provider could not verify which, if any, staff were allocated to provide one to one night time cover on the dates referred to above. Overnight support for this person was removed in December 2015, following a review by the placing authority. Instead, a door alarm was installed on the bedroom door of the person. This discreetly alerted staff that this person had opened their bedroom door and had possibly left their room. Staff were required to respond immediately to the alarm to locate the person and ensure that the person and other people were safe.

Following the removal of the one to one night support, staff told us that the alarm was responded to and the person was returned from other people's rooms or other parts of the home. However, staff told us that they did not believe the measures in place for this person were effective. Two staff said that the alarm had not always been responded to in a timely way. On occasions, when staff responded to the alarm, they said that they had left people in the middle of being cared for. On at least one occasion, the alarm was found not to be working and had been stored in the office for a period of time. The home cannot be certain in this instance that the person did not leave their room and that no one came to harm. The concerns about the

effectiveness of these arrangements were not escalated to the placing authority or anyone else.

There were six alleged incidents between 8 December 2015 and 16 May 2016 where the person had gained access to other people's bedrooms, despite the alarm being installed. This included an alleged incident in March 2016 that warranted a referral to the local authority safeguarding team, informing the police, notifying CQC and immediate action to protect people from the risk of abuse. Although this alleged incident was recorded on the person's daily notes, no further action was taken by staff or the manager until the local authority became aware of the issue in May 2016. The provider's safeguarding policy and incident policy had not been followed. The local authority's safeguarding guidance had not been followed. The failure to take action in relation to an alleged serious safeguarding incident and other concerns placed people at significant risk of harm. Since mid-May 2016, one to one overnight support had been in place. Following our inspection, we made an immediate alert to the host borough and placing authority to review the current arrangements to ensure people were safe. One to one support was subsequently extended to 24 hour a day one to one support.

This is in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.□

The people who were at direct risk of abuse from a person's behaviours, and the person exhibiting the behaviours each had care plans and risk assessments in place. The care plans described the risks. The most recent risk assessments were compiled for each of these people in April 2016. These risk assessments had been signed and dated each month since to indicate monthly review had taken place. However, it was evident that the risk assessments had not been fully reviewed or amended since the alleged serious incident in March 2016 or since the seriousness of the alleged incident had been fully realised in May 2016. The risk assessments did not reflect that the risks to people were continuing and that risk reduction measures did not appear to be working.

The person who was posing a risk had their care plan reviewed but this did not reflect that the door alarm installed had not been an effective means of warning staff that the person had left their room. There had been a further six instances where the person had entered other people's rooms and potentially posed a risk to them. The person's care plan and risk assessments had not been reviewed to take account of these risks.

This is in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

Care UK's (The provider) policies for reporting incidents and accidents and safeguarding people from abuse are clear about the timeline for reporting and reviewing concerns. The Accident / Incident reporting policy states that serious incidents should be reported without delay to a senior member of staff on duty who in turn must ensure that immediate action is taken to safeguard people. The person receiving the report must also ensure that the necessary notification forms are completed and that the incident notifications are referred to the relevant agencies, including the local authority and CQC. The safeguarding policy states that safeguarding incidents should also be referred without delay. The area operations manager informed us that the registered manager of the service is required to review incidents to identify trends each week.

On 18 September 2015, CQC were informed by the home that a safeguarding concern had been sent to Islington social service department about an alleged incident which occurred on 25 August 2015. The authority informed CQC that the concerns were substantiated and that the failure to notify the concern in a timely way had been attributed to an agency nurse. The manager of the home at the time said the nurse had failed to report the concern and had also failed to care for other people when they were on duty. The current manager was not in post at that time so could not inform us of what action was taken, although the local authority had informed CQC previously that the agency nurse in question had been stopped from working at the home.

There was significant delay in reporting and responding to the August 2015 alleged serious incident which left the victim and others at the home at risk of harm. During this inspection, we found that the alleged incident on 25 August 2015 was not logged on care records and there was no copy of the notification on the safeguarding central record kept at the home. CQC had received the notification from the home but this was not recorded on any documentation or electronic record held at the home.

A further alleged serious incident occurred on 23 March 2016 which warranted referral to the local authority safeguarding team, the police and CQC. The home failed to take appropriate action at the time which potentially placed people at significant risk of harm. The local authority safeguarding team were not notified until 6 May 2016 by the home. CQC was not notified by the home about the incident as per the provider's and local authority's procedures. The CQC Registration Regulations 2009 state that "Subject to paragraphs (3) and (4), the registered person must notify the Commission without delay of the incidents specified in paragraph (2) which occur whilst services are being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity.2 (e) any abuse or allegation of abuse in relation to a service user. CQC became aware of the alleged incident at a meeting with the local authority in mid July 2016.

The accident / incident policy states that an analysis of reports is undertaken by the provider's Clinical and Care Governance Team. Our review of both care notes and the accident / incident log clearly showed that care and/or nursing staff had recorded the alleged incident. The service had failed to take the necessary steps to report this in line with procedures and this had delayed any attempts to put measures into place to mitigate the risk of further incidents. The provider's Clinical and Care Governance Team had not reviewed

the alleged incidents, as when we asked at our inspection if they had we were told there was no information to show that these had been reviewed. Subsequent to our inspection the provider reviewed accident / incident records and found a further six alleged incidents that were then reported as safeguarding alerts to the local authority in respect of the same clients. These were alleged incidents that had occurred up to late April 2016 although no further incidents have been reported since the service introduced 24 hour one to one support for a specific client.

This is in breach of Regulation 18 of the CQC Registration Regulations 2009.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider was not notifying significant incidents as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not taking all necessary measures to keep some people safe from avoidable harm or abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Risk assessments were not being updated for some people to reflect changes to the risks they faced.