Homewards Care Ltd

Homewards Limited - 48 Leonard Road

Inspection report

48 Leonard Road
Chingford
London
E4 8NE

Date of inspection visit:
29 August 2019

Date of publication:
25 October 2019

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Homewards Limited - 48 Leonard Road is a residential care home providing personal care to four people with a learning disability or autism spectrum disorder.

The service has not been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

People's experience of using this service and what we found
People were not always supported by staff who had been recruited to the service in a safe manner. We identified issues with staff references.

Staff were identified to work excessive hours within this service and another service. This put people at risk of unsafe care as staff were not having a sufficient break before caring for vulnerable people.

Risk was assessed and provided information on how to reduce people's known risks and manage behaviours that challenged the service. However, specific details as provided by staff on how they managed individual risk was not always documented in the risk assessment.

The service had an outdoor washing machine which was not stored in a suitable building and the electrical source posed a health and safety risk as they were using an extension cable and not an outdoor plug.

The service was free from malodour and was generally clean but, people's bedroom windows and a downstairs bathroom were unclean, and wires were found hanging from a bedroom which posed a health and safety risk to people.

Records showed people received their medicine on time. However, where people may require medicine on an as needed basis there was no guidance on when staff should administer them. We have made a recommendation about the safe management of medicines.

Accidents and incidents were recorded but, staff told us learning did not always take place after their occurrence.
We have made a recommendation about learning after accidents and incidents.

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.

The service didn't always consistently apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.
The outcomes for people did not fully reflect the principles and values of Registering the Right Support as people did not always receive safe personalised care.

Quality assurance was not effective and failed to identify the issues found with staffing, recruitment, health and safety issues or the cleanliness of the service. Audits sent to us were not detailed or current.

The registered manager was not aware of their duty of candour responsibilities when things went wrong and they did not make themselves present despite being on the rota on the day of the inspection.

Continuous learning and improvements were not always shared with staff at the service. We were told this was done at management level. We have made a recommendation regarding continuous learning and sharing improvements with staff.

Staff knew how to identify abuse and raise concerns to the registered manager or to the local authority and the CQC.

Staff told us they could approach the registered manager and meetings were held to discuss the service which involved people who used the service.

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

Rating at last inspection – The last rating for this service was good (published 9 August 2018).

Why we inspected
We received concerns in relation to the management of medicines and staffing. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other Key Questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the Safe and Well – Led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Homewards Limited - 48 Leonard Road on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe recruitment, staffing, safe care and treatment and quality

assurance processes.

Please see the action we have told the provider to take at the end of this 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well- led

Details are in our well-led findings below.

Homewards Limited - 48 Leonard Road

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 was carried out by two inspectors.

Service and service type
48 Leonard Road is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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
This inspection was unannounced.

What we did before the inspection
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. We used all of this information to plan our inspection.

During the inspection
We spoke to three staff, including two care workers and a registered manager from another one of the provider's services. We spoke to two people who used the service.

We reviewed a range of records. This included four people's care records and associate medication records. We looked at five staff files in relation to recruitment.

After the inspection
We spoke to the registered manager of the service and continued to seek clarification from the provider. We also requested and were sent further quality assurance records.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- Recruitment records were not always robust to ensure people living at the service were supported by staff who were safe to work with them.
- We found the latest employer's details had not been used for reference checks with no explanation as to why and the details provided for personal references did not match the application.

The above was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Sufficient numbers of staff were not deployed to ensure people were kept safe.
- We viewed the rota for four weeks and noted that every shift had been marked as covered.
- However, we found staff were often working 24 hour shifts and found to be working at other services without a visible break. This put people at risk where staff may be excessively tired.
- At this service there were supposed to be three staff on duty, one of the staff being the registered manager. On our arrival at the inspection there were only two staff on site to support four people. This put people at risk of not receiving care in a safe and timely manner.

The provider did not deploy staff appropriately which put people at risk of harm. The above issues were a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- People's risk assessments contained information on how to reduce risk however, specific details staff explained to us were not present in the risk assessments. For example, staff told us one person was at risk of harming their head. Staff reduced this by placing their hands over sharp corners of furniture however this was not stated in records we checked. Nevertheless, staff showed they knew how to protect this person in a safe manner.

- We found a washing machine had been placed outside the home in the garden. This was not housed in a safe building and was plugged in using a standard plug. This was dangerous as a standard plug in an outdoor setting posed an electrical and fire risk. We informed the local fire brigade of our concerns.
- The London Fire Brigade completed an inspection in August 2019 and found areas the service needed to improve upon to ensure the safety of people living at the service in the event of a fire. At the time of the inspection we had not be assured by the service they had met the requirements of the fire brigade.

● People living at the service had personal evacuation plans. However, these were not personalised to support each person with their different needs while leaving the property. We informed one of the directors of this during the inspection and they advised this would be rectified.
● Within a ground floor bedroom, we found loose cables hanging from a window, this posed a health and safety risk for people.
● During the inspection we showed a member of staff these concerns in relation to the wires and informed the director during feedback. Evidence was not provided to show how these issues were rectified by the service.

Due to gaps in risk assessments and health and safety issues, people were put 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.

● The service assessed risk in the following areas to protect people from harm: behaviour, medicines, personal care and accessing the community.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risks of abuse as staff had been trained in safeguarding procedures and knew the different types of abuse people could face.
● Staff showed they would not accept people living in the service being abused or facing any harm.
● Staff told us they would report allegations of abuse to the registered manager and where no action was being taken they would report further to the local authority, person's GP, their relatives or to the Care Quality Commission (CQC).

Using medicines safely
● Staff received training in the safe administration of medicines and supported people to take their medicines on time.
● We viewed medicine administration records (MAR) for each of the people living at the service and found no gaps in the MAR chart.
● Opening dates of medicines had been recorded to ensure staff did not administer out of date medicines.
● Staff did not have a protocol to follow when they administered medicines on a "as required basis" (PRN), such as paracetamol. We asked for one, but it could not be produced during or after the inspection.

We recommend the provider refers to current guidance on the safe management of PRN medicines.

Preventing and controlling infection
● Staff followed safe hygiene practices and were provided with personal protective equipment to prevent the risk of cross infection.
● The home was free from malodour however, windows in people's bedroom and a downstairs bathroom were unclean. We could also see a number of cobwebs present in the bathroom.
● We showed one of the directors and they advised this would be rectified, however we were not sent any evidence to confirm this had been done.

Learning lessons when things go wrong
● Staff advised they did not take part in any exercises on learning lessons after incidents.
● The registered manager advised lessons learnt took place during manager meetings. They said, "Best practice is shared amongst managers, going forward we will share with staff."

We recommend the provider refers to current guidance in the management of accidents and incidents and the learning that can be taken from them.

Inadequate

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The service had a registered manager however; they did not make themselves available for the inspection despite being on the rota for the service and had been made aware by staff and other managers they were needed at the service.
- Staff told us they knew what was expected of them and this was discussed during supervisions.
- We were sent an infection control audit after the inspection which had no date or name to confirm when it had been completed or by whom. We could not be assured infection control audits were being completed on a regular basis.
- After the inspection we were sent the directors audit which was carried out every two months, but the audits sent related to the previous June and August 2018 and none were submitted for this current year.
- Audits within the service did not identify concerns with recruitment, staff deployment, health and safety concerns and cleanliness within the service. This meant we could not be assured of an effective quality monitoring system within the service.

There was a lack of effective audit systems to ensure the safety and quality of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The registered manager was also the nominated individual for another service (a nominated individual is responsible for supervising the management of a service on behalf of the provider). They were unable to demonstrated their duty of candour responsibilities, and could not explain what duty of candour meant.
- Staff told us they thought the service was well run. A member of staff said, "Yes I do think it is well managed."
- The registered manager told us they operated an open-door policy where staff could speak to them when they needed to.
- Staff told us they could approach the registered manager or call them with any concern and they were listened to. A member of staff gave an example of how they had requested certain repairs to be carried out and this had been acted on promptly.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Records confirmed the service held residents' meetings where people were able to provide feedback on the service. We were sent evidence of this after the inspection. Staff confirmed these meetings took place.

● Staff told us they attended meetings, and these were useful to discuss people's needs and how to keep them safe within the service and out in the community.

● Relatives, staff and external health professionals were given the opportunity to provide feedback on the quality of the service through a survey. A staff comment from the survey stated they enjoyed working at the service.

Continuous learning and improving care

● Learning was not taking place with staff within the service. Staff we spoke to told us they were not always informed where learning may have taken place, in the associated service (where the registered manager was the nominated individual). They advised a short briefing discussing the individual service but no best practice took place. This meant best practice and improvement opportunities may have been missed as sharing of information with staff did not take place.

We recommend the provider refers to current guidance regarding continuous learning and sharing improvements with all staff.

Working in partnership with others

● The registered manager told us they worked with a number of different local authorities and has built up a good working relationship with each of them.

● The registered manager told us they also attended provider forums where best practice was shared and important updates received from the adult social care community.

● The service also worked with different health professionals such as occupational therapists, psychologists, general practitioners and speech and language therapists.

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 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for people who used the service, in relation to assessing risk and mitigating risk. 12 (1) (a) (b) (d) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes established were not operating effectively to monitor the quality of service provide to people. 17 (1) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Persons employed for the purpose of carrying out the regulated activity must be of good character. Recruitment procedures must be established and operated effectively. 19 (1) (a) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient number of suitably qualified, competent, skilled staff were not deployed to meet people's needs. 18 (1)