London Care Limited

London Care (Willow House)

Inspection report

Willow House
Victoria Court
Wembley
Middlesex
HA9 6EB

Date of inspection visit:
28 November 2018

Date of publication:
18 March 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection of Willow House took place on 28 November 2018. It was an announced comprehensive inspection. At the last inspection in November 2017 the service was not meeting two regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This scheme provides care and support to older people and people with mental health needs living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. Willow House is a purpose-built block of flats on three levels, containing 40 flats. People remain independent and live in their own flat within their community. 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. There were 38 people living at the scheme at the time of this inspection.

The service had a registered manager in place. 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 scheme had auditing systems to ensure they met legal requirements. However, these had not identified the shortfalls we identified during our inspection. The scheme was not consistently undertaking mental capacity assessments or escalating concerns relating to capacity to relevant authorities.

Joint working arrangements and shared services promoted co-ordinated person-centred care. However, we judged the scheme still needed to develop further links with the local authority in managing admissions. We judged that more joint working could improve access particularly in situations where people could choose their own care provider from an external agency rather than the on-site care team if they so wished.

At this inspection we found that improvements had been made. Risks were being planned for, managed and mitigated appropriately. Risks associated with people's care and support needs had been identified in care records along with guidance about how to support people to keep them safe.

The scheme had taken steps to respond to concerns we raised in the previous inspection about the management of risk for people with dementia. The scheme was now offering more tailored assistive technology to support individuals to complement support from care workers.

The scheme had clear systems to keep people safe and safeguarded from abuse. All care workers received up-to-date safeguarding and safety training appropriate to their role. Staff checks were also carried out on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required.

There were sufficient care workers on duty to meet people's needs and keep them safe. Care workers worked in an unhurried way and met people's individual needs. Rotas suggested there were sufficient staff deployed to support people. Extra care workers were made available if needed.
There were appropriate systems for safe handling of medicines, health and safety and infection control. These systems were subject to regular auditing. The management had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Although there were elements of good practice in the application of the Mental Capacity Act 2005, this was not across the board. Improvements had been made relating to the use of liberty restricting measures such as location devices, door sensors and the use of verbal distraction techniques. However, decisions about capacity were not consistently taken and reviewed in a structured way. We judged that further improvements were required in this area.

Care workers received supervision and annual appraisal on a regular basis, even though these would have benefited from being more detailed to reflect what had been discussed and what actions had been agreed. New care workers had undergone a thorough in-house induction which included shadowing experienced care workers. Additionally, there was evidence of on-going essential training.

People were supported to maintain their health and wellbeing by accessing external health and social care professionals. Care records demonstrated when health professionals had been involved and recorded treatment interventions. People were also supported to have sufficient amounts to eat and drink. Their care plans contained detailed information about food and drink.

Care workers treated people with compassion, dignity and respect. There was polite and friendly interaction with people. They took time to ensure people's privacy and dignity were maintained.

Care workers had a good understanding of the need to protect people's human rights. They had received equality and diversity training. The scheme treated people's values, beliefs and cultures with respect.

People received personalised care and support that was specific to their needs and preferences. Their care and support was planned and delivered in a way they wished.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the end of this 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?

Good

People told us they felt safe. Risks associated with people's care and support needs had been identified in care records along with guidance about how to support people to keep them safe.

There were clear systems to keep people safe and safeguarded from abuse. The scheme carried out staff checks on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required.

The scheme had systems for appropriate and safe handling of medicines.

Care workers had completed infection control training and had access to personal protective equipment.

Is the service effective?

Requires Improvement

We found elements of good practice in the application of Mental Capacity Act 2005. However, further improvements were needed.

Care workers received supervision annual appraisal on a regular basis. There was evidence of on-going essential training.

People were supported to have sufficient amounts to eat and drink.

People were supported to maintain their health and wellbeing by accessing external health and social care professionals.

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Is the service caring?

Good

Care workers treated people with compassion, dignity and respect. Care workers were focused on the needs of people with dementia, and took time to make them as comfortable as possible.

Care workers had a good understanding of the need to protect people's human rights. They had received equality and diversity training. The scheme treated people's values, beliefs and cultures with respect.

Care workers were knowledgeable about people's preferences. People's care records contained recorded key information about their care. This included people's likes and dislikes, gender, interests, culture and language.

Is the service responsive?

Good

The scheme remained responsive to people's needs. People told us they received care when they wanted it.

People's care plans were regularly reviewed and any changes in their needs were communicated to care workers. Their families, health and social care professionals were involved.

People knew how to raise a concern or complaint if they were unhappy. There was a complaints policy in place which was available to people.

Is the service well-led?

Requires Improvement

The scheme had auditing systems to ensure they met legal requirements. However, these had not identified the shortfalls we identified during our inspection.

There were systems and processes for learning and continuous improvement. The scheme made use of internal and external reviews of incidents and complaints to make improvements.

London Care (Willow 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 carried out an announced, focussed inspection of the scheme in November 2017, at which two breaches of legal requirements were found. This related to how the service managed risks to people and the general governance of the scheme, respectively.

After the focussed inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. We undertook an announced follow-up comprehensive inspection of Willow House on 28 November 2018 to check that they had followed their plan and to confirm that they now met legal requirements.

The inspection team consisted of two adult social care inspectors, a specialist social worker, and an expert by experience. An expert by experience is someone who had personal experience with this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We also reviewed the information we had about the scheme such as statutory notifications.

We spoke with 16 people using the service, the registered manager, deputy manager, the regional manager, seven care workers and a social care professional.

We looked at records in relation to eight people to see how their care and treatment were planned and delivered. Likewise, we looked at eight personnel files of care workers. We also looked at records relating to the management of the service, including a selection of the provider's policies and procedures.

Good

Is the service safe?

Our findings

At the last inspection in November 2017 we identified shortfalls which placed people at risk of harm. The scheme was rated 'requires improvement' in this key question. At this inspection, we found that the scheme had made improvements required to comply with the regulations. The scheme is now rated 'good' in this key question.

People told us they felt safe living at the scheme. At previous inspections, we identified that risks were not being planned for, managed and mitigated appropriately. At this inspection we found that improvements had been made. Risks associated with people's care and support needs had been identified in care records along with guidance about how to support people to keep them safe. Each person had a set of individualised risk assessments. Staff we spoke with were aware of risk management, as were members of the management team.

The scheme had taken steps to respond to concerns we raised in the previous inspection about the management of risk for people with dementia. Previously, we had identified that there was a risk that people with dementia or higher needs were not properly supervised. At this inspection, we found the scheme had made improvements and was now offering more tailored assistive technology to support individuals. For example, people were provided with remote alarm systems, and locator devices for use in emergencies. This was used to complement support from care workers.

At our previous inspection in November 2017, the scheme did not have an admissions criterion. This meant, there was a risk of inappropriate admissions. At this inspection we found out that the scheme now had admissions criteria in place. Therefore, admissions were only agreed if it had been assessed that the care would be appropriately delivered, and in that way managing risk proactively.

The scheme had clear systems to keep people safe and safeguarded from abuse. All care workers received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Where safeguarding concerns had been identified, records confirmed the registered manager had taken appropriate action to respond to these. Policies were regularly reviewed and were accessible to all staff. They outlined who to go to for further guidance.

The scheme carried out staff checks on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). This included undertaking checks of identity, qualifications, gaps in employment and seeking appropriate references.

Our observations, together with discussions with staff, showed there were sufficient care workers on duty to meet people's needs and keep them safe. Care workers worked in an unhurried way and met people's individual needs. Rotas suggested there were sufficient staff deployed to support people. Extra care workers were made available if needed.

The scheme had systems for appropriate and safe handling of medicines. We looked at some medicine administration records (MARs) and their associated care records. Each person had their own profile sheet which contained information to correctly identify the person and to assist are workers to administer medicines safely. Care workers signed the MAR after administration. This assured us that medicines were given as prescribed and were available.

Records showed care workers had received training in medicine administration. Competency checks had been carried out to ensure they were safe to support people with their medicines. People told us, "Staff support me with my medicines. I know what they are giving me." Another person told us, "I receive my medicines in the morning and evening from staff. They tell me what I am taking."

Care workers had completed infection control training and had access to personal protective equipment, such as gloves and aprons to reduce cross infection risks. There were supplies of gloves and aprons available.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in November 2017 we found the scheme was not effective. The principles of the Mental Capacity Act 2005 (MCA) were not always understood and followed. At this inspection we found that improvements had been made, however further improvements were needed.

The MCA 2005 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. We checked whether the scheme was working in accordance with the MCA Act.

We looked at a sample of care files and saw that mental capacity assessments had been carried out. However, this practice was inconsistent and consent was not always sought in line with the principle of the MCA. For example, four records of people using the service contained a range of capacity assessments, which showed that they lacked capacity to make specific decisions in areas such as weight management or risk management. We saw that decisions relating to these areas had been made but there was no evidence that relevant people had been involved in these decisions, such as the people's next of kin.

In another example, a person had a mental capacity assessment about 'risks around wandering'. There was no evidence that the scheme had attempted a discussion with the person nor were there reasons given as to why capacity was not presumed. The scheme could not provide evidence to demonstrate the steps taken to demonstrate that this person lacked capacity. This was common of other decisions we viewed.

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. As the scheme is not a care home, any applications to deprive people of their liberty must be made to the Court of Protection by the local authority. There were no people subject to court orders for their restriction. People were free to access the community as they wished. Since our last inspection, improvements had been made relating to the use of liberty restricting measures such as location devices, door sensors and the use verbal distraction techniques. The regional manager was aware that the scheme needed to make improvements in their documentation of family involvement and others interested in the welfare of people, when making decisions that may amount to restriction.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent.

Care workers received supervision annual appraisal on a regular basis. We identified that supervision records would benefit from being more detailed to reflect what had been discussed and what actions had been agreed. Care workers told us that they felt supported by the registered manager and senior staff. New care workers had undergone a thorough in-house induction which included shadowing experienced care workers. This gave them the skills to carry out their roles and responsibilities effectively. Care workers new to care were undertaking the Care Certificate which had been introduced in April 2015 as national training in

best practice.

Additionally, there was evidence of on-going essential training, including health and safety, infection control, first aid, moving and handling, safeguarding, nutrition and healthy eating and medicines management. Records confirmed care workers were up to date with their training. Where refresher training was due this had been scheduled. Care workers were also supported to receive additional training to meet the specific needs of people they care for such as catheter care, dementia and continence care.

These were bespoke courses, specific to the needs of people living at the scheme. This meant the service recognised people's diversity and ensured care workers were trained to support them effectively. One person told us, "Staff are good. They check you every day. They help me with shopping. They ask if I am well throughout the day. If you ask them they come and attend to you, they do."

People were supported to have sufficient amounts to eat and drink. Their care plans contained detailed information about food and drink. Although care workers were not always required to prepare people's meals, there were reminders in people's care plans for them to always leave drinks within easy reach. The service supported people from different cultural and religious backgrounds. Some people required support with food preparation. We saw that care workers supported people with this, taking into consideration of people's cultural needs.

People were supported to maintain their health and wellbeing by accessing external health and social care professionals. Care records demonstrated when health professionals had been involved and recorded treatment interventions. People had been referred promptly to health professionals when required; this included the GP, occupational therapists (OT), physiotherapists, district nurse team and the speech and language team (SALT).

Good

Is the service caring?

Our findings

The scheme remained caring. People were positive about the caring attitude of the care workers. Their feedback included, "Care workers are very good. They keep your spirits up. You can't criticise them for not caring", "Care workers treat you with respect and dignity" and "I like all of them. They are a lovely bunch. I am very well looked after."

We observed that care workers treated people with compassion, dignity and respect. There were polite and friendly interactions with people. Care workers took time to ensure people's privacy and dignity were maintained. People with dementia were treated with understanding and without judgements. We saw that care workers were focused on people's needs, and took time to make them as comfortable as possible.

People's privacy was respected. People confirmed care workers knocked on doors before entering their apartments. Care workers kept doors closed and curtains drawn when they were attending to people's personal care.

The scheme recognised people's rights to confidentiality. Care records were stored securely in locked cabinets in the office. There was a confidentiality policy in place, which complied with General Data Protection Regulation (GDPR) law. The GDPR law came into effect on 25 May 2018. It is Europe's new framework for data protection laws.

Care workers had a good understanding of the need to protect people's human rights. They had received equality and diversity training. The registered manager was familiar with relevant policies, including The Human Rights Act 1998. The service treated people's values, beliefs and cultures with respect. There were practical provisions for people's differences to be observed. For example, provisions were made for people who preferred to get care from same gender staff to have their needs met.

Care workers were knowledgeable about people's preferences. People's care records contained key information about their care. This included people's likes and dislikes, gender, interests, culture and language. This information enabled care workers to involve people as they wished to be. Rotas were organised so that people received care, as much as possible, from regular care workers.

People were supported to maintain their independence. The care plans highlighted the importance of independence by directing care workers to prompt people to increase eating or dressing independence. Care workers were knowledgeable about each person's ability to undertake tasks related to their daily living. This ensured they could give the right support people to participate as fully as they could. They prompted people to attend to their personal care where possible, as opposed to doing everything for them. One person told us, "They go through the care plan with you. They ask what you need. I try to be independent otherwise I feel useless and they know that."

Good

Is the service responsive?

Our findings

The scheme remained responsive to people's needs. People we spoke with told us they received care when they wanted it and care workers did what was required of them. One person said, "It was my choice to live here. My social worker organised it." Another person told us, "I am Roman Catholic. They have a priest who comes every Sunday morning."

People received personalised care and support that was specific to their needs and preferences. Their care and support was planned and delivered in a way they wished. Prior to people moving to the scheme, the registered manager or deputy manager visited them and carried out an assessment of their needs. We saw from signed records that people and their families were included in the admission process. People were asked for their views and how they wanted to be supported. The pre-assessment fed into the care plans. The care plans provided clear guidance to care workers about people's needs and their daily routines.

There were reduced staffing levels during the night, limited to emergencies rather than routine care. As a result, the scheme operated variable tailored packages of assistive technology to support individuals. Most people living at the scheme had difficulty performing activities of daily living independently. Some people needed assistance with toileting, mobility, cooking and dressing. Assistive technology promoted greater independence by enabling people to perform some of these tasks independently. We saw that some people used pendant alarms, location devices such as wrist watch (GPS), chair and bed sensors. For example, electronic sensors assisted care workers to manage risk and help people to stay in their flats if they wished to. Location devises ensured people could access the community without being accompanied by staff.

People's care plans were regularly reviewed and any changes in their needs were communicated to care workers. Their families, health and social care professionals were involved. For example, we saw that the scheme had made an appropriate referral for someone who had been identified as requiring support from an OT. This could be evidenced in other records we reviewed. This meant people received appropriate support and care promptly when required.

We looked at how the provider complied with the Accessible Information Standard (AIS). The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. People had information about their communication needs in their care plans to guide care workers on how to ensure they had the information required. Staff ensured people had communications aids as required.

People's diversity and human rights were respected. The service had a policy on ensuring equality and valuing diversity. This gave guidance to care workers to ensure that the personal needs and preferences of all people were respected regardless of their background. Care workers were knowledgeable about what they would do to ensure people had the care they needed for a variety of diverse needs, including spiritual and cultural differences. People were supported with their religious observances, including visits to church and mosque. People's spiritual needs were supported. Their feedback included, "I get my Guajarati paper. I

pray here", "I am a Seventh Day Adventist. I go to church" and "I am a Catholic. Sometimes the priest visits."

People were supported to take part in social activities. One person told us, "I used to go to the day centre. I was encouraged by staff." Another person said, "They offer exercises and bingo." We observed that care workers interacting with people in the communal areas. They played bingo and puzzles with them. People with dementia were invited to communal areas and supported to mix with others to help avoid loneliness and social isolation.

People knew how to raise a concern or complaint if they were unhappy. There were no complaints recorded but during the course of the inspection we became aware that there had been a complaint. Following the inspection, the registered manager told us it was being addressed. There was a complaints policy in place which was available to people. One person told us, "There is paperwork, which explains what to do to make a complaint. I have not had any disagreements." Another person said, "I will inform the office. I also go to residents' meetings, where I can raise concerns."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in November 2017, we identified a breach in regulation regarding how the scheme was managed and the well-led domain was rated as 'requires improvement'. This was because the provider did not effectively assess, monitor and improve the quality and safety of the service provided.

At this inspection, we found that the scheme had auditing systems to ensure they met legal requirements. However, these had not identified the shortfalls we identified during our inspection. The scheme was not consistently undertaking mental capacity assessments or escalating concerns relating to capacity to relevant authorities. The regional manager was implementing systems to improve this. However, we could not be assured as this remained 'work in progress'. We have therefore rated this key question as requires improvement.

We asked people of their general impression of Willow House and if they felt it was well managed. Their feedback included, "Willow House is a good place", "I would want to live here permanently. I like it here. It is very comfortable" and "I have had a good time since I moved here."

The managers had taken on board the feedback from our previous inspection. They had established policies, procedures and activities to ensure safety, and assured themselves that they were operating as intended. Previously they had been no admissions procedure. This had now been put in place and systems had been put in place for its review. An escalation process had also been developed for situations where people's health deteriorated to ensure all key partners were involved in care reviews at the earliest opportunity.

The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated, person-centred care. On the other hand, the scheme still needed to develop further links with the local authority in managing admissions. We reviewed some referrals that had been declined by the scheme. Some of these referrals had been declined for safety considerations, including reduced staffing at certain times. However, we judged the scheme could improve access for people by liaising more with the local authority, principally in situations where prospective individuals could choose their own care provider from an external agency rather than the on-site care team if they wished. We found that the registered manager understood these challenges and was willing to work with other agencies to address them.

There were clear responsibilities, roles and systems of accountability to support good governance and management. Care workers understood their lines of responsibility and accountability for decision making. The management team demonstrated a strong commitment to providing people with a safe, good quality and caring service and to continually improve. We spoke with the deputy manager, registered manager and regional manager, who were familiar with important operational aspects of the scheme. We found them to be well-informed about their roles.

Structures, processes and systems to support good governance and management were clearly set out,

understood and effective. The scheme had further developed its systems to assess and monitor the quality and safety of the service. Enhanced systems relating to quality monitoring medicines management, handover, finances, key-working, people's activities, and care plans had been introduced and were being monitored.

There were systems and processes for learning, continuous improvement and innovation. The scheme made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements. We identified accidents had been recorded and had been analysed for identifying trends and learning.

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 11 HSCA RA Regulations 2014 Need for consent The provider was not always meeting the requirements of the MCA in respect of decisions made for people using the service.