Help At Home (Egerton Lodge) Limited

Help at Home (Connaught House)

Inspection report

Victoria Place
Loughborough
Leicestershire
LE11 2EY

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11 August 2021
12 August 2021

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Help at Home (Connaught House) is an extra care scheme. Extra care scheme's operate in purpose-built properties, which provide accessible and safe housing for older and younger people to live independently. At the time of our inspection, 34 people were living at the scheme. Not everyone who used the service received personal care. Care Quality Commission (CQC) only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
Consistent numbers of skilled and knowledgeable staff were not always deployed to keep people safe and meet their needs in a timely manner. Staff did not always stay for the full duration of care calls. The provider was taking action to make improvements. It was not possible to assess the impact of improvements at the time of inspection as these were at a very early stage. Staff were recruited safely.

Medicines were not always administered safely or as prescribed. People had experienced missed medicines due to missed care calls, including time critical medicines. The provider had introduced more robust audits and checks and planned to re-train staff to reduce the risk of further errors.

Quality assurance was undertaken but was fragmented and systems and processes could not demonstrate any improvements made were sustainable. The provider had failed to ensure systems and processes were established and operated effectively at all times to monitor and improve the quality and safety of the service. They had not identified poor leadership and governance within the service or listened to or taken action when staff raised concerns.

Care plans required review to ensure consistent information was recorded in people's risk assessments and associated care records, and information reflected people's current needs.

People and staff spoke positively about the interim management team and the changes they had made to improve the quality of the care and support provided. Staff spoke of improved morale and confidence in raising concerns and making suggestions. The provider had developed an improvement plan and was working towards making the improvements required to ensure people received safe, quality care.

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 under the previous provider was Good (published 29 February 2020).

Why we inspected
The inspection was prompted in part due to concerns received around poor leadership and governance, staffing and medicines. 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 requires improvement. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Help at Home (Connaught House) on our website at www.cqc.org.uk.

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 monitor the service to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to staffing, how medicines were administered and leadership and governance of the service.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our reinspection 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?

People were not always safe.

Details are in our safe findings below.

Requires Improvement

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement

Help at Home (Connaught House)

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector and an Expert-by-Experience. An Expert-by-Experience is a person who has experience of using or accessing this type of service.

Service and service type
This service is an extra care scheme. It provides personal care to people living in their own flats to enable them to live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care; this inspection looked at people's personal care and support.

The manager, who was registered with the Care Quality Commission, had recently left the service. The service was being overseen by an interim management team which included the regional director. This meant that the provider is 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 48 hours' notice of the inspection. This was because we needed to ensure the management team would be available on site to support the inspection.

Inspection activity started on 11 August 2021 when we visited the registered location and met with managers and people using the service. We undertook telephone calls to people using the service, relatives and staff on 12 August 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. 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 11 people who used the service to gain their views about their care and support. We spoke with six members of staff including the regional director, the interim care manager and care and support staff. We contacted four relatives by telephone who were able to share their views on behalf of their family members.

We reviewed a range of records. This included four people's care plans and records and a sample of medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and information and provider action plans.

Requires Improvement

Is the service safe?

Our findings

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to 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.

Staffing and recruitment

● Prior to our inspection, people and staff raised concerns with us that there were not enough staff available to care for people safely. During our inspection, people told us there were enough staff to make them feel safe, though they had to wait for assistance when the service was short staffed. Comments included, "Staff don't always turn up for my well-being visit, but I don't worry because I know that they are all very busy", "The staff are usually kind and caring unless they are in a hurry and can be a bit brisk and "I don't know everyone who works here because they change so often."

● Staff told us there were still times when there were insufficient numbers of staff in the service. Comments included, "Staffing levels can still be low at times. A couple of weekends ago there were only two of us on duty when there should have been five. I worked in excess of 12 hours without a break. I was exhausted and that isn't safe. I know they are trying to recruit but no one seems interested in applying," and "Things are improving, they [managers] are trying to recruit but there is a long way to go. Staffing is still dire at times." Staff told us low staffing levels meant people received minimal support and well-being checks [checks on people's welfare] did not take place.

● We reviewed call schedule records for week starting 8 August 2021. Records showed there were many occasions when staff failed to stay for the full duration of the call. For example, one person was scheduled a 30 minute call. On one occasion they received a 20 minute call and on another occasion they received a 9 minute call. Staff did not record reasons why care calls were shortened in duration. This put people at risk of not receiving the full care they needed.

● We discussed staffing levels with the regional director. They told us short term, unplanned staff absence had had a significant impact on staffing levels and the provider had started to implement measures to address this. Additionally, recruitment of new staff had been very slow and had not attracted many suitable applicants. The provider was working to address this and agency staff were used in the meantime. The regional director acknowledged that sometimes staffing levels were low but contracted care hours (hours commissioned by the local authority to meet people's needs) were delivered, though the service was scaled back. They also acknowledged that staff were failing to record reasons why they were not staying the full duration of the call. They told us they were reviewing the care people needed with commissioners hours as some people's needs had changed. They were also working with staff about spending quality time with people.

The provider had failed to consistently ensure that sufficient numbers of staff were deployed to keep people safe. This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the provider was working to address staffing concerns, the impact could not be assessed during this inspection.

● Staff were recruited safely. Recruitment records showed pre-employment checks, such as criminal record checks and identity checks had been done. References for staff had been received and recorded. These checks helped to ensure staff were suitable to provide safe care to people.

Using medicines safely

● Prior to our inspection, we received information of concern about people's medication not being administered safely. The concerns raised included poor record keeping and missed medicines.

● We reviewed medicine administration records for June and July 2021. These showed over 12 incidents where people had not received their medicines, including time critical medicines. Errors were recorded due to missed care calls or staff administration errors. This put people at risk of harm from risks associated with medicines which were not administered as prescribed.

● The provider had taken action to make improvements through more robust work allocation processes and regular auditing of medicines. However, we found continued gaps in medicines administration records which audits had identified as staff errors. The regional director told us they were in the process of arranging competency training for all staff.

The provider had failed to ensure people's medicines were administered as prescribed. Staff responsible for the management and administration of medicines did not receive regular reviews to ensure they remained competent. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management;

● People and relatives told us they felt safe using the service. People had a range of risk assessments in place regarding their care. Where risks were identified, records did not always provide consistent information about how to keep people safe. For example, a risk assessment for a person requiring a hoist to transfer was detailed in terms of how to use the equipment. However, the person's daily routine care plan made no reference to the use of a specific glide sheet or that the person required re-positioning. Re-positioning records were not fully completed and did not indicate which side the person had been re-positioned to. There was a risk that re-positioning may not be carried out effectively in order to protect the person from pressure areas developing.

● Records to monitor people's distressed behaviours were not consistently completed. Whilst some information was recorded in handover care notes; it was not always clear how they were reviewed to inform people's risk assessments and care plans. This meant opportunities to provide a timely response to changes in people's behaviour could have been missed.

● The provider had identified care plans and records were in need of review and updating but had yet to allocate resources to undertake this work.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● The provider had a safeguarding and whistleblowing policy and procedure in place but these had not been operated effectively. We found staff had a good understanding of safeguarding and whistleblowing procedures. However, they felt their concerns had not been listened to or acted upon under previous management and action had not been taken until they had raised their concerns with external agencies.

● The provider had acknowledged this failing and had taken action to support staff to raise concerns and share information. This included more robust safeguarding and whistleblowing processes, staff forums and more effective partnership working with other agencies. Staff told us things were much improved. They now felt confident to raise their concerns with managers and these were listened to and acted upon.

● Records showed, where accidents and incidents had occurred, these had been analysed and lessons learnt to prevent re-occurrence. Actions included referrals to other agencies and staff re-training.

Preventing and controlling infection

● People were protected from the risk of infection. The provider had ensured there was sufficient stock of personal protective equipment (PPE) in place. The provider worked in partnership with the housing provider to ensure communal areas were safe to use. We saw staff wearing PPE appropriately when supporting people.

● The provider took action to ensure all staff followed appropriate infection control measures, such as hand washing. This included spot checks and audits to promote safe practices and compliance with current guidance. People were supported to keep their homes clean and communal areas were kept clean and hygienic by staff.

● Regular testing was in place and staff and people were supported to access vaccinations for COVID-19.

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.

At our last inspection this key question was rated as good. At this inspection this key question has deteriorated to 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Prior to our inspection, we received information of concern about poor management and leadership and the fact that the registered manager was rarely onsite. This was in part, due to the fact that they were also the registered manager for one other extra care housing schemes under the same provider. The registered manager had left the service prior to our inspection but had yet to cancel their registration with the Care Quality Commission.
- Staff described a culture where they were felt unsupported, bullied and intimidated by the registered manager when they were in post. When they had attempted to raise concerns about the leadership and management, they felt they had not been listened to by the provider until the intervention of external agencies. Several staff members had left due to this change in culture.
- The provider had recognised they had failed to have robust systems and processes in place to ensure they maintained effective oversight of the leadership and governance of the service; particularly through COVID-19 pandemic. This meant there were times when people did not receive safe, quality care. The provider had implemented an interim management team. However this was a temporary arrangement until a new, suitable registered manager was appointed. Quality assurance was fragmented and carried out based on priority of risk and concerns. It was not possible to assess if improvements made under the interim managers were sustainable to ensure people consistently received good care.

The provider had failed to ensure systems and processes were established and operated effectively at all times to monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Prior to our inspection, the regional director had developed an improvement plan which detailed what improvements had been identified and how these would be made. This included carrying out regular audits to ensure areas such medicines, staffing and call schedules could be monitored effectively.
- Revised audits and checks had only very recently been implemented and therefore it was not possible to assess the impact of these improvements at the time of this inspection.
- People did not always feel able to share their views or feel involved in decision making. One tenant told us,

"We don't have tenant meetings anymore and would like to have these as these were useful. If I have any concerns, I go to housing as I don't know where else to go." Systems were being developed to involve people using the service and staff in how the service was run. These included tenant meetings and drop in sessions with the interim manager.

● Relatives did not know who the manager was or who to go with concerns, other than the general office. One relative told us, ""If I say something to one staff member on one day and it's a different staff member there the next day, they know nothing about it. There is no continuity of care."

● Staff meetings were taking place and further staff consultation through staff forums was planned. Staff told us they felt more involved and consulted. One staff member said, "Morale is on the up thanks to [regional director] and we now feel able to raise concerns and make suggestions. If we say things need to change, it happens. Progress is slow and change cannot happen overnight but we are moving in the right direction."

Working in partnership with others; 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

● The provider had recognised areas of concern around the commissioning of some extra care packages. They were working with the local authority and other agencies to review people's needs as a priority.

● The provider understood the requirements and their responsibilities under the duty of candour. They were open and honest about where things had gone wrong and that improvements were required.

● Staff confirmed this open approach which they appreciated and had given them some assurance that the provider was committing to putting things right.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure people's medicines were administered as prescribed. Staff responsible for the management and administration of medicines did not receive regular reviews to ensure they remained competent.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure systems and processes were established and operated effectively at all times to monitor and improve the quality and safety of the service.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to consistently ensure that sufficient numbers of staff were deployed to keep people safe