Angel Kids 2 Limited

Corbett Care

Inspection report

448-450 Green Lane
Ilford
Essex
IG3 9LF

Date of inspection visit:
08 February 2017

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04 May 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 8 February 2017. This was the first inspection of the service since it was registered in 2014 as the service did not support any people until recently.

The service is registered to accommodate up to ten people with learning disabilities who may also have mental health needs. People living at the service were in receipt of direct payments and were supported by two personal assistants during the daytime and by staff employed by the service during the evening and night. There was one person using the service at the time of our inspection.

The home did not have a registered manager in post, although a prospective manager had been appointed at the time of writing this report. 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.

People were not protected against the risks associated with the unsafe management and use of medicines, as medicine recording and administration records were not accurate. Staff did not receive regular competency checks to ensure they had the correct skills for administering medicines.

Records relating to the recruitment of new staff showed relevant checks were not always completed before staff worked unsupervised at the home.

A safeguarding procedure flow chart was in place and staff were aware of their roles and responsibilities to report safeguarding concerns. However, not all staff had undertaken recent, up to date safeguarding adults training and they were not clearly aware of the signs and symptoms of abuse. They did not have access to an up to safeguarding procedure and relevant contact numbers. We did not see clear guidelines for staff about the circumstances in which restraint was to be used and if staff had considered other, less restrictive techniques prior to this.

Staff did not have clear guidance about how to manage and mitigate risks. Some risks relating to managing people's health condition and behaviours that challenged were in place. However, risks relating to people's other specific needs such as their awareness and understanding of danger, for example, when undertaking outdoor activities and road safety, management of medicines, allergies and fire safety were not in place.

CQC requires registered services as a part of their registration to notify the Commission when there are incidents of a safeguarding nature or the police are called out to a home. We found that not all of the required notifications had been made to the CQC.

Staff were not supported to carry out their role through regular supervision and support, nor did they have relevant training to meet people's needs.

We saw people had a hospital passport. However, this was not comprehensively completed in order to promote people's health and wellbeing.

Staff had completed training in relation to MCA. However, not all staff understood the principles of the Act and how to support people in line with these.

The provider did not have sufficient systems in place or continuous oversight to make improvements in all aspects of the service and address the deficits we found in the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

During our inspection we found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version 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?

Inadequate

The service was not always safe.
Staff were not appropriately checked before they started work.
Staff were not clearly aware of the signs and symptoms of abuse or the procedure to follow if abuse was suspected. Not all staff had completed safeguarding adults training.
The service did not have a robust medicines policy and procedure in place for staff to follow.
There was a lack of comprehensive risk assessments for people placing people at risk of harm.

Is the service effective?

Requires Improvement

The service was not always effective.
People's care plans did not always contain information guided by the principles of the Mental Capacity Act 2005 (MCA).
People were not always supported by staff who had the skills and knowledge to carry out their roles and responsibilities.
Staff had not been provided with support through regular supervision.
People's health and wellbeing were at risk of not being met because of lack of clarity around responsibility for this between people's relatives and staff.

Is the service caring?

Requires Improvement

The service was caring.
Staff were kind and respectful and treated people with dignity and respect. However, people's history and communication methods need to be added to support plans to improve communication.
The staff were friendly and polite when providing support to people.

Is the service responsive?

Requires Improvement

The service was not always responsive
People had care plans in place however they did not cover all aspects of people's individual needs.
We found the registered provider had a general complaints procedure in place, which was not personalised by the service. It was not available in a clear and accessible format.

There was not a range of activities for people to engage with.

Is the service well-led?

Inadequate

The service was not always well-led.
Audits were not regularly carried out in the home. Records in the service were not all up to date and clear.
Notifications to tell CQC about safeguarding incidents had not been made as required.

Corbett Care

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.

This inspection took place on 8 February 2017 and was announced. The provider was given 24 hours' notice because the location provides a learning disability service to younger adults who are often out during the day; we needed to be sure that someone would be in.The inspection team consisted of one inspector.

Before the inspection, we considered information received from external stakeholders and statutory notifications. A notification is information about important events which the provider is required to send us by law.

During the inspection, we were unable to speak with people who use the service because they did not communicate verbally. We spoke with one member of staff, a nurse care co coordinator involved with people using the service and the provider of the service. We looked at care and other relevant records of people who used the service, staff records and a range of records relating to the running of the service.

Inadequate

Is the service safe?

Our findings

All the people we met required high levels of personal care and support with all aspects of daily living. We were not able to seek people's views about the service because they did not communicate verbally.

The service did not have a satisfactory system in place to ensure that staff were suitable to work with people in need of support. We checked all of the staff recruitment files and found that the provider's recruitment procedure did not follow the principles of safer recruitment. One staff member's file did not contain any references and the provider had not checked if the staff member was barred from working with people in need of support. The other two files each contained one character reference but none relating to conduct in previous employment in health or social care.

The provider was unaware of the requirement to check whether staff were barred from working with people in need of support before they started work. This was pointed out to them following a visit to the service by the local authority commissioning team. We saw that the provider had since checked three staff members but one remained outstanding. Therefore, the provider had not taken sufficient steps to make sure that people were protected as far as possible from staff who may be unsuitable to work with people in need of support. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

A safeguarding procedure flow chart was in place. Although the service had a policy and procedure for safeguarding people in place, this was provided by an external company and was a generic version. It was not personalised to Corbett Care and information was not easily accessible to staff. Two of the four staff had not undertaken recent safeguarding adults training. Staff were not clearly aware of the signs and symptoms of abuse or the procedure to follow if abuse was suspected.

The provider informed us that people who used the service were subject to restraint to prevent harm to themselves and others in the home. We saw that all staff had received restraint training, including the personal assistants. We saw that the personal assistants and Corbett Care staff used an ABC record (noting what occurred before, during and after the behaviours, recorded in a hard back book) about when/ how people were restrained and how long for. We did not see a risk assessment or clear guidelines for staff about the circumstances in which restraint was to be used and if staff had considered other, less restrictive techniques prior to this. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks were not appropriately assessed with strategies in place for staff to mitigate those risks. We found that risk assessments were part of support plans. Although risk assessments relating to some aspects of the support provided were in place such as managing epilepsy and behaviours that challenged, they did not fully take account of people's other specific needs and their awareness and understanding of danger and risk. For example, for outdoor activities and road safety, management of medicines, allergies and fire safety.

People were not protected against the risks associated with the unsafe management and use of medicines.

We looked at the medicine administration procedure followed by staff and checked the Medicines Administration Record (MAR) charts. We found that medicines were handwritten onto MAR charts. We found that the staff and the provider had not correctly recorded the names and strength of the medicines and administration instructions were not clearly stated. For example, errors in recording for a liquid medicine which was recorded on the MAR chart as 200mcgm/5 ml to be taken twice daily, whereas the label on the medicine said 200 mg/ 5 ml, take four 5 ml spoons twice a day. We also saw two boxes of clonazepam tablets which were taped together and did not have a visible instruction label.

We found that staff frequently administered 'as required' medicines to people (known as 'PRN' medicines). There was no PRN protocol in place to ensure staff were aware of the circumstances in which the medicines should be administered.

Staff had undertaken on line administration of medicines training. There were no records to show that their competency to administer medicines safely had been checked, in order to ensure that they were following the correct instructions for medicine administration and keeping accurate records.

At our inspection we found that the service was not registered with the environmental health agency and we were also informed of poor food safety management by another agency who had visited the service prior to our inspection. The provider informed us that they will follow this up as soon as possible. All of the above is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Requires Improvement

Is the service effective?

Our findings

All the people we met required high levels of personal care and support with all aspects of daily living. We were not able to seek people's views about the service because they did not communicate verbally.
At the time of inspection the service supported people who had learning disabilities, were on the autistic spectrum and had epilepsy.

A professional told us "We provide regular support to [the person] to make sure [they] are ok. The arrangement is not ideal and is disjointed."

Staff had not been sufficiently trained to carry out their role and support people living in the service. We looked four staff files and found that most of the training undertaken by staff was at previous places of employment. The most recent training undertaken by staff was the use of restraint which was delivered by external trainers at the service. This was attended by the personal assistants who supported people at the service during the day, a person's relative and staff employed by the service, who supported people during the evening and night. Staff had not undertaken training in health and safety, moving and handling, food hygiene, fire safety, autism and learning disabilities awareness. Staff informed us that they had undertaken completed e- learning training in medicine management and the Mental Capacity Act 2005.

We asked to see what induction staff had received before they started working at the service. Although there was a list of induction topics, such as understanding your role, duty of care, equality and diversity, this was a list on a piece of paper and there was no detail about when it was delivered, what it entailed or how staff understanding and competency were assessed after they completed the training.

We found that staff files contained documentation for Common Induction Standards, a set of standards for social care workers that were superseded in April 2015 by the Care Certificate. This was blank in each file.

The service also used agency staff. We asked how the provider checked if the right agency staff were being employed in the home. The provider explained that the agency only sent staff who were familiar with the people who used the service and had the necessary skills to provide appropriate support. It was unclear how the provider checked the detail about staff the agency supplied. The agency staff had not received an induction to the service or relevant up to date training. This meant people were being care for by staff who had not been made familiar with the needs of people using the service.

We looked at how staff received support at the service in relation to supervision and guidance to carry out their role. We checked four staff files and found that the last supervision meetings were carried out in September and November 2016 by the previous manager. A supervision meeting is held between a staff member and their manager to discuss any concerns, their progress and training requirements. Staff told us they received supervision. We asked the provider if they had a supervision matrix to monitor staff supervision meetings. They did not have this. This meant that staff did not always have the opportunity to review their practice or behaviours with the management team to help drive improvement in the way they provided support to people who used the service. This was a breach of Regulation 18 of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider informed us that people's main representatives were responsible for maintaining their health and wellbeing. They transported people to any health appointments and liaised with the health professionals directly on behalf of people. The representative attended appointments with people. Therefore, the representative received correspondence relating to people's health appointments and managed these according to their own availability. We were informed that this caused confusion and people often did not receive the health care they needed in a timely manner.

We saw people had a hospital passport. However, this contained basic information about people's health care needs and only listed their medical conditions. It was not comprehensively completed outlining how these presented and actions required to manage these, the behaviours people presented, their communication methods and how these should be managed in order to promote people's health and wellbeing.

People routinely saw their GP's, nurse practitioners and dentists as well as mental health practitioners. However, we are concerned that the dual responsibility between people's representatives and staff at Corbett care for managing people's health care needs, may mean that staff may not act consistently on issues identified, putting people's health and wellbeing at risk. This was a breach of Regulation 12 (2) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found one person whose DoLS application had been authorised as they did not have the capacity to make decisions.
Staff told us they had completed e-learning training regarding MCA and the training records confirmed this. When asked about consent to care, staff said they would seek people's consent before providing care and support. They told us they would never force people to do anything they did not want to, but would try and encourage people or try again if unsuccessful. However, staff understanding of the MCA was variable. We recommend the service provide refresher MCA training to all staff so that they are clear about their role and responsibility under the MCA.

Requires Improvement

Is the service caring?

Our findings

All the people we met required high levels of personal care and support with all aspects of daily living. We were not able to seek people's views about the service because they did not communicate verbally.

On the day of the inspection there was one staff member employed by Corbett Care present at the service. People were supported by their personal assistants. We observed staff interacted with people in a friendly manner and were able to communicate with them. Staff said they knew the people who used the service well and knew how to respond to them.

Each person had their own room where they were permitted privacy. Staff were aware of the need to maintain people's privacy and dignity and said they would knock on doors and ask before entering people's rooms. Staff told us the importance of informing people of what was going to happen during care.

Staff told us how they supported people to do as much as they could for themselves and recognised the importance of promoting people's independence. One staff member told us, "We need to promote independence as it is important. We can promote this by encouraging people to do their personal care."

Support plans we saw did not include information about how people were involved in their care and making decisions about their care, in an inclusive way. The staff were aware of people's needs and the level of support they needed. They encouraged people to do as much as possible for themselves. However, people's history and how they communicated was not clearly stated in the support plans.

Information relating to people and their care was held in the office. The office had a door lock ensuring people's information remained confidential.

Requires Improvement

Is the service responsive?

Our findings

All the people we met required high levels of personal care and support with all aspects of daily living. We were not able to ask people who lived at the service about the contents of their care plan and their involvement with them because they did not communicate verbally.
A professional told us, "[The person] is not in the best placement. We are supporting the placement as best we can. [Their] needs are not being considered as a priority."

People's needs were not appropriately assessed when they moved into the service, nor was care planned and delivered to meet those needs. When people moved into the service, we saw there was a joint assessment of their needs undertaken by staff of Corbett Care and other professionals involved in their care. Support plans were developed based on this assessment, however, these only covered a few areas such as nutrition and hydration, personal care, health, behaviour support and epilepsy support, when people required support with every aspect of daily life.

Support plans were not always comprehensive and did not include pertinent information for staff so they knew how to support the person according to their needs, preferences and wishes. For example, we saw that one person had a positive behaviour support in place to support them to manage their behaviours. This person did not communicate verbally, and instead used gestures and facial expressions to communicate their needs, however their positive behaviour support plan did not include their preferred communication methods. There were no specific guidelines in place for staff to recognise how to pre-empt a situation and how people expressed pain, pleasure, disapproval or agreement with any of the tasks that were carried out by the staff.

People's likes, dislikes and preferences were not clearly stated in support plans. Development of personalised support plans which give guidance to staff about people's specific care needs, communication methods and how best to support them in differing situations, are key requirements in ensuring people received care and support in accordance with their identified needs and wishes. This information is required when there is a new and changing staff group as well as when people accommodated do not communicate verbally.

People did not receive adequate stimulation and were at risk of social isolation, as the provider had not identified appropriate, meaningful activities so that people could undertake activities safely. The provider informed us that people were supported to engage in a range of indoor and outdoor activities, depending on how they were feeling. on the day of the inspection, we observed that there was no activity plan in place for people, they spent most of the time indoors with the staff and we saw that they were mainly in an agitated state. A professional told us "[The person] needs to go out and do activities. This does not always happen." We observed that there was little interaction between people and the personal assistants. The provider told us that they were unable to arrange or plan any meaningful activities with people because of the unpredictability of their behaviours. The service did not understand how to support people to express their views and did not use different methods of communication to interact with people. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a complaints policy and procedure in place. This was provided by an external company and was a generic version placed in a folder. It was not personalised to Corbett Care and information was not in an easily accessible format. The registered provider told us they
had not received any complaints since they registered with CQC. We recommend that the provider develops a complaints policy and procedure which is accessible to people, their relatives and stakeholders in order to encourage them to give their views and raise concerns or complaints.

Inadequate

Is the service well-led?

Our findings

Staff and professionals told us that the provider was approachable and supportive.

We found that the provider did not have adequate systems in place to assess and monitor the quality of the service in order to drive improvement. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services. This ensures that they provide people with a good service and meet appropriate quality standards and legal obligations. There were no clear management and reporting structures because the service did not have a registered manager in place, in overall charge of the service. At the time of writing this report an interim manager had been appointed by the service.

Due to the dual arrangement of the staffing structure in the home, with staff of Corbett Care and personal assistants providing support within the service premises at different times, it was difficult to assess how staff can be clear about their roles and responsibilities. We did not see job descriptions or contracts of employment on staff files. Due to lack of a manager, staff did not have clear leadership, support and direction for their work.

The service was provided in a large house, with rooms on two floors. We observed that all areas of the home were in need of refurbishment and updating. The provider told us that they were aware of this and a refurbishment plan was being developed.

Due to the lack of a manager no internal monthly audits relating to the service were carried out in order to assess compliance with regulations as well as areas for improvement. The service had been without an effective quality monitoring system for a significant period of time. All of these audits are necessary to make sure the service was safe and met people's needs.

An external consultant had carried out a comprehensive quality audit of the service in January 2017 and had identified significant areas for improvement. The provider gave us reassurance that they would ensure that effective systems were established and put in place to make significant improvements to the service in a timely manner.

All of the concerns identified in this report mean that the provider did not have sufficient systems or continuous oversight to make improvements in all aspects of the service. The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The provider had not notified CQC of reportable events, for example we found two notifiable events relating to safeguarding people and a hospital admission that took place which had not been reported to CQC. This was a breach of regulation 18 of the Care Quality Commission (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 did not notify the Commission without delay of allegations of abuse relating to the service user, or of incidents reported to the police. Regulation 18(1) and (2)(e) and (f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not design care or treatment with a view to achieving people's preferences and ensuring their needs are met. Regulation 9(1) and (3)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure care was provided to people in a safe way, through assessing and mitigating risks, ensuring the proper and safe management of medicines or by ensuring timely care planning took place when responsibility for people's support was shared. Regulation 12(1) and (2)(a), (b), (g) and (i).

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

	The provider did not operate effective systems and processes to ensure service users are protected from abuse and improper treatment. Regulation 13(1), (2) and (4)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have sufficient systems in place to assess, monitor and improve the service people received; assess, monitor and mitigate the risks relating to the health, safety and welfare of people who use the service and others who may be at risk; and seek and act on feedback from relevant persons. Regulation 17(1) and (2)(a), (b) and (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not operate effective recruitment systems to ensure person employed were of good character. Regulation 19(1)(a) and (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that staff received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18(2)(a).