Mr H G & Mrs A De Rooij

Knowsley Road

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This unannounced inspection took place on 12 January 2015. At our last inspection, on 16 January 2014 we had found there was a breach of Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, regarding staffing numbers and training. The provider sent us an action plan to tell us that this would be addressed by 01June 2014. We found on this inspection that the breach had been dealt with.

The home required a registered manager. 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. At the time of this inspection, the registered manager was away on leave and the service was being run by one of the providers who was the also the registered manager at another of their homes, with the support of the provider's health service manager.

Summary of findings

The service was registered to provide care for 24 people and at the time of our inspection, there were 15 people resident although one of these was in hospital. The people supported by the service all had mental health needs and some had additional physical needs.

The home was in a pair of adapted, semi-detached Victorian houses. The building was dark and cold in places.

We found that people were happy and felt safe but they complained of being cold. Their dignity and privacy were not respected as staff entered rooms sometimes without knocking. People were not given a choice about many of the aspects of their daily life such as when to have a snack. Staff were supported and trained but they were not conversant with the Mental Capacity Act (2005) or the associated Deprivation of Liberties Safeguards. The management style was not appropriate to the people being supported and the way the home was run did not allow people to live their lives freely or independently.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponded to regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.. You can see what action we told the provider to take at the back of the full version the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People told us they felt safe and staff had been trained to safeguard people and were able to tell us about abuse.

Staff recruitment processes ensured that the required checks were made before staff started employment and there were sufficient staff on duty throughout the day

Good

Is the service effective?
The service was not always effective.

Staff were trained and supervised but were not able to tell us about the Mental Capacity Act (2005) or the Deprivation of Liberty Safeguards.

People had not been assessed for their mental capacity and their independence was not encouraged or enabled.

Requires Improvement

Is the service caring?
The service was not always caring.

People were not involved in the home or in planning their care.

We saw no evidence of supporting people to be more independent

Requires Improvement

Is the service responsive?
The service was not always responsive.

We saw little evidence of person centred care. People had limited choice about much in their daily life.

People did not receive emotional or physical stimulation as there were no planned activities

Requires Improvement

Is the service well-led?
The service was not always well led.

The manager and staff did not demonstrate a positive culture of open and transparent working.

The people who lived in the home were not encouraged to give feedback on the service that they received.

Requires Improvement

Knowsley Road

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 12 January 2015 and was unannounced. It was carried out by a team of three people; a lead Adult Social Care inspector, a second Adult Social Care inspector and a specialist advisor, who was a registered nurse.

We viewed the current information we held on our systems. The provider had sent us an action plan after the last inspection. We reviewed notifications made to us by the service. We received information from the Local Authority and from the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We observed the care of the people living in Knowsley Road; spoke with nine people, six care staff, the two managers of the service and with one visiting health and social care professional. The provider held most of the information about the home electronically. We reviewed five staff files and case tracked three people with their care records. We reviewed other records, including audits, the training matrix and various policies, many of which the provider emailed to us after the inspection.

Good

Is the service safe?

Our findings

One person told us, “Been here a long time, yes I do feel safe here”. Another, when asked if he felt safe at Knowsley Road said, “Yes I do”.

One staff member told us, “All medications are given on time and it’s important to keep to set times”. A staff member said, “I completed safeguarding training during my induction; we get plenty of training” and another said, “We always manage and have enough staff on duty; day and night”. A visiting professional told us, “I think he [the person he was supporting] is very safe here and is able to raise any worries with the group he goes to”.

We viewed the medicines room and saw that medications were kept safely in this locked room which was clean and ordered, and that the medicine trolley was also locked. Controlled drugs were stored appropriately and we observed that all medicines were administered following the providers’ policy which instructed that two staff, one of whom should be a medicines trained senior, were to administer and witness the record.

The medication administration records (MAR) were correctly filled in and had photographs of the person they referred to except for any people on respite care. The pharmacy supplied MARs for those people on respite. The MAR sheets running totals of drugs administered tallied with the amounts of medications left in storage. We saw that all medication records were up to date.

We saw that the senior support staff member on duty the day of our inspection had qualified NVQ level 3 and had been assessed to give medication. She had undergone her annual medication training update in January 2015. We saw from the training matrix record, that all the senior staff for the service had received similar training. This meant that staff were up to date with medication training.

We reviewed individual staff files and saw that all the appropriate checks had been made prior to the commencement of employment. We saw that an induction period had been managed and that the completion of the providers required training had been achieved.

Staff told us that they received training in various aspects of the service including safeguarding and whistleblowing, during their induction and that this was refreshed afterwards at various intervals. We saw from the training matrix that the majority of staff had received induction or refresher training in safeguarding and whistleblowing, in the last year. Staff members we spoke with were aware of the whistleblowing procedure and said they would use it if necessary. Staff were provided with personal alarms to alert other staff members if there was an emergency, but we found that one staff member was not wearing theirs as it had been left in the office.

We saw staffing rotas for four weeks before our inspection and found that staffing levels were adequate. Staff told us that there were enough staff on duty, day and night.

We discussed with the provider and health service manager the lack of safeguarding notifications made to us. We had received information in October 2014 and we had referred it to the local authority safeguarding team. We had not received any notification from the provider. The provider told us that they had felt this was a complaint and not a safeguarding issue. We advised them that the issue was a safeguarding issue and the provider should have notified us. The provider told us that this would be done retrospectively and for any such similar events if they occurred.

The kitchen was clean and odour free and we were told that it currently had a food hygiene rating of four out of a possible five. The kitchen was still in the process of being re-fitted, the cook told us and this had been the reason for the rating.

We saw that staff wore appropriate personal protective clothing when conducting their domestic duties and when serving meals.

The fire equipment around the home had been regularly checked and was in date and emergency fire procedures were displayed around the home.

Requires Improvement

Is the service effective?

Our findings

One person told us, "Sometimes staff come in of a morning and open the window. Sometimes it`s windy and cold, I shut the window when they`ve gone out". Another said, "It could be a lot warmer. It`s so cold sometimes we need to keep our coats on, we are not allowed heaters in our rooms".

Another person told us, "We can only have three biscuits of a night time, you can`t have any during the day" and someone else said, "People get drinks at the same times every day but they can't make their own drinks, it`s to do with safety". A person told us, "I`ve asked for a hot breakfast but they said if we do it for you we will have to do it for everyone" and another said, "I`d love a hot breakfast, but we can`t have it. They [staff] say if we do it for you they will all want one. We only have toast, cereal or porridge".

The manager told us that choice of food had been offered in the past and went on to say, "It doesn't work; we have tried it before" and "It's all about costings".

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) is part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

No one living in the home had a DoLS at the time of our inspection. and we were later told that no applications had been made for any of the people living there.

The senior support staff said that they got MCA training via the Social Care Information and Learning Services (Scils) which was an online learning resource for the Health and Social Care Sector. However, she could not explain the MCA or its practice, at any level.

The MCA Code of Practice states that the five statutory principles of the MCA form a vital part of developing a patient's care plan and should be integral to this process. Knowlsey Road was a home for people with mental health illnesses. There was no evidence of the MCA being applied to practice in any of the files looked at. There was no evidence of any best interest's meetings of any best interest decision's being followed.

Staff told us that none of the people living in the home self-medicated as they had all been assessed as not able to retain the information. There was no evidence of any such assessment or of a best interest meeting in the care plans we viewed.

We saw that one person's care notes stated that they refused to have a check up to identify if they had other medical problems, We saw in their daily diary notes, an entry which stated that, 'The GP states that [name] has the capacity to make the decision not to go into hospital'. Another record in the person's care notes stated that there were, 'Concerns regarding [name]'s decision making and mental capacity to make appropriate decisions in relation to his health care needs'. This showed that there was conflicting information about the person's capacity to make decisions about their health care needs. There were no capacity assessment or best interests meeting decision with regard to this and there was no care plan to support this person to get the best possible health care. We found this was the situation in all the care plans we viewed.

These examples are breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 , which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had not ensured that there were suitable arrangements in place to act in accordance with the consent of people who lived in the home.

The home had originally been two semi-detached houses and had been made into one residence by knocking through walls and adapting the whole building to accommodate communal rooms and facilities.

We found that lighting was dim and that the temperature in the home, especially in the dining room and lounge, was cool. The provider told us that someone had reset the timer and that this would be adjusted immediately which we noted was done, as the temperature rose during our visit, after we had told the provider, However, people told us that the low temperature was normal and that they were usually cold and had to wear coats and heavy jumpers to

Is the service effective?

keep warm. We had also been made aware of this issue, through some of the information we had received, prior to this visit. We noted that the concerns had been over the last several months.

In the people's rooms we viewed, all the décor was the similar with little evidence of personalisation and all the doors to the rooms were the same, with no personalised identification on them. There were communal bathrooms, shower rooms and toilets and the laundry room was equipped with an up to date washing machine. The passenger lift was not working and the provider told us that the engineers were waiting for parts to repair it. The provider assured us that the people in the home with mobility problems were already accommodated on the ground floor. The environment was clean but we found there were unpleasant odours in several areas of the building.

The provider had two services and staff moved between them as necessary. This meant that continuity of care could be compromised. The records for both services were often combined, such as the staff training matrix. This showed that staff had undertaken mental health awareness and DoLS training via Scils. We saw that other subject areas had mostly been regularly trained and refreshed, such as manual handling, medicines, fire safety and infection control. However, there were three staff members who had been scheduled to have management training in February 2014. Only one had completed this and the record showed that the other two were 'awaiting start'. One staff member had completed eight training subjects on the first day of their employment in 2007 and had not refreshed these since that date.

A staff member told us, "We now do training on the computer. I like it; I can take my time to do it".

When asked about the covert use of medication they stated that, "We never administer medication covertly, the policy says we can't" and that "People who don't understand care are usually compliant". The staff seemed happy and told us they felt well supported. One told us, "I really like working here; we get good training and supervisions every two months".

We were told that some people did not eat enough due to their mental illness and that nutrition was a problem. We were told and saw in the records that that nutritional advice had been sought for people living in the home. There was a four weekly menu. Staff told us that all the people ate in the dining room at set mealtimes.

We saw that people had expressed a choice over food which may have given more calories to them, but the opportunity had been denied. People told us that they would have preferred a hot breakfast each morning. At breakfast on the day of our inspection, we asked nine people if they would prefer a hot breakfast and all but one put their hand up. We saw no sign of choice of food at lunchtime as there was no alternative offered.

We saw that there was no evidence of independent access to food and drinks. We noted that mealtimes were very tightly kept to. Staff confirmed this was the case and told us this was because people benefitted from having a very regimented and ordered routine. We asked whether people could have a snack or a drink at other times and were told them that this was not allowed, even if they had missed a meal. People themselves told us they were not allowed to have a kettle or a box of biscuits or sweets in their own room and there were no facilities in the communal areas to either make a hot drink or have one from some form of machine. We were also told by staff that people having a kettle would be at risk from scalding themselves. We saw no evidence that risk assessments or best interests meetings had taken place regarding these activities, which meant that people were not supported to make choices and to take risks.

These examples are breaches of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 , which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had not ensured that a choice of suitable food was available to people living in the home.

Requires Improvement

Is the service caring?

Our findings

One person told us, “Staff have keys to our rooms and sometimes just come in, like of a morning”, however, we saw that they did knock on people’s doors before entering. Another said, “I think the care is good. I like the staff, some of the have been here a while so they know us”.

The manager told us, “Those people who are able to make a drink, should move”. He went on to say, “Having structure in place, it’s why we are recommended”.

We observed that the staff were caring and appeared knowledgeable about people’s needs and that they were patient and supportive with them.

The manager’s language when talking about the people was disparaging and not person centred. When asked about the care of people who may be at the end of their life he talked about, ‘Shipping them out to Melrose’. [The providers’ other home].

We saw that there was a notice on the notice board near the entrance which stated ‘Let’s be Dignity Champions’. A ‘Dignity Champion’ is someone who believes passionately that being treated with dignity is a basic human right, not an optional extra. They believe that care services must be compassionate, person centred, as well as efficient, and are willing to try to do something to achieve this. We did not see any evidence that this practice had been adopted.

There was no evidence of advance care planning for end of life in the care files. There was no evidence of people’s choices or preferences for end of life care planning. We saw that people had no involvement in the running of the home and in planning their own care. We saw no evidence of enabling and supporting people to be more independent. We were told that one person helped others in running errands for them, but we did not observe much social interaction between any of the other people or involvement apart from at mealtimes.

Most of the people had voluntarily agreed to being cared for at Knowsley Road. This meant they were under no restrictions imposed on them. However, we had conflicting information about the ability of people to have privacy. People had keys to their own rooms but we were told that staff used their own keys to gain access without the person’s permission. These issues were not appropriately recorded or risk assessed to demonstrate why staff would need to do this.

These examples are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 , which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had not ensured that people’s dignity and privacy was respected and that they participated in making decisions relating to their care.

Requires Improvement

Is the service responsive?

Our findings

One person said, “Sometimes they [staff] do things without asking us”. Another said, “If there was something wrong I would tell one of the staff. I have never had to complain though”

The manager told us, when we asked about people not having much choice in their daily lives, “They can like it or leave it”.

A staff member told us about activities, “They can’t concentrate because of the drugs”.

The care plans we viewed were very basic and did not cover the holistic nature of good care planning. There was no evidence of the care plans identifying social and spiritual needs and requirements of the person. There was no evidence of people’s continued involvement in the care planning process and review. We observed that personalised care was not evident and that the care was structured for the majority and not for the individual. The medication round observed was regimented and did not take a person centred approach.

We observed that staff gained a people’s consent before any intervention, that staff supported people in line with their care plans and that they could explain the individual needs of people.

There was no evidence of any sensory or physical stimulation. Activities were limited as there was no activities worker. We were told that people were able to go out independently and that group trips were offered but were not popular. The TV was most peoples preferred activity, staff told us. They went on to say that four people were physically unable to go out.

The complaints procedure was displayed on the notice board and staff said they would support people to make a complaint if necessary. There had been no complaints made in the last year.

Requires Improvement

Is the service well-led?

Our findings

One person told us, "I have not seen the manager for a while. She has been off but she`s OK". Another said, "I think the care is good – I like the staff, some of the have been here a while so they know us".

A staff member told us, "If I am not sure of anything I can always ring someone. We have a manager on call at all times".

Regarding a 'residents survey', the manager told us "Haven't done one in about two years; there's no timescale".

The manager, who was also the provider, told to us that he was a qualified mental health professional of many years standing. However, we did not see evidence of current best practice in his leadership of the service at Knowsley Road. We had not received any notifications from the provider since our last inspection. The registered manager had been absent from the service since November 2014 which was over 28 days at the time of our inspection. There is a legal requirement for providers to inform CQC if this happens and this had not been done. We were assured this would be and we did receive a notification shortly after our visit. The provider told us that they would re-visit the CQC website to refresh them about which notification need to be made to us and when.

We were assured that suitable management arrangements were in place to cover the registered manager's absence, which were that the provider who was a registered manager at their other home, and the provider's care manager, would oversee the management of Knowsley Road.

The service had been audited regularly and this included checks on things such as care plans, risk assessment, and checks on the building and environment, such as emergency equipment and the kitchen. The audits we viewed showed that the service was satisfactory. However, in light of our findings we questioned this. We were sent the service's business contingency plan which included what to do if an evacuation of the building was necessary.

We were told by the manager that residents' meetings were held every three months and that the last 'residents meeting' had been in September 2014. This was four months previous to the date of our inspection. We were told that the notes of this meeting were not available as the home's administrator had left their job before Christmas. The manager told us that he would get a staff member to type them up. This meant that the notes had not been available for the residents to comment upon for their accuracy.

The manager told us that the last residents' survey had been two years ago and there were no plans to do another one. He told us that they found out people's views as they talked with them This meant that there was no recent record of what people thought about the service.

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 did not take formal enforcement action at this stage. 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 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The provider did not have suitable arrangements in place for obtaining and acting in accordance with the consent of service users.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The provider did not offer a choice of suitable and nutritious food and hydration in sufficient quantities to meet service users' needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **The provider did not have suitable arrangements in place to ensure the dignity, privacy and independence of service users.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider did not have suitable arrangements in place for obtaining and acting in accordance with the consent of service users.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The provider did not offer a choice of suitable and nutritious food and hydration in sufficient quantities to reach the service users' needs.
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The provider did not have a suitable arrangements in place to ensure the dignity, privacy and independence of service users.