Creative Support Limited

Creative Support - Donnybrook Court Extra Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 15, 17 and 23 March 2016. On the first day the inspection was unannounced, and on subsequent days the service was aware that we were returning. This is the first inspection of this service since it registered in February 2015.

Donnybrook Court is an extra care service which provides care and support to 75 older people and people with physical disabilities. There are two sites, Donnybrook Court and Duncan Court, both of which consist of 40 self-contained flats, with shared facilities such as a lounge, dining room and launderette. At the time of our inspection 40 people were living at Donnybrook Court and 35 at Duncan Court.

The service had a registered manager, who is the Area Manager for Creative Support. 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 our inspection, there were service managers in place for each building, and one of these site managers intended to become registered manager for the whole service. However, both buildings were managed as separate services, and managers have informed us they intend to review the service's registration.

People who used the service benefitted from a varied and interesting activities programme. The service had innovative activities on both sites, although we saw that this programme was more developed at Donnybrook Court than at Duncan Court.

People had detailed care plans with summaries for staff to follow. We saw evidence that these plans incorporated people's wishes and preferences and had detailed information on how to ensure people's dignity and independence was maintained. However, care plans at Donnybrook Court were frequently inconsistent and were not regularly reviewed, and people were not receiving the hours they were allocated from the local authority. Measures were in place to ensure that people had consented to their care, and that when people may not have the capacity to do so, the service had worked in line with the Mental Capacity Act (MCA) 2005 in order to assess people's capacity and to work in line with people's best interests.

Risks to people were assessed and management plans were put in place in order to manage these. Not everyone had a personal evacuation plan, but the service had identified this and had measures in place to address this. It was not always clear that people were receiving support from two staff when a risk management plan required this, and in one instance the risk management plan may not have been adequate to address the risks to a particular person.

People's safety was promoted through an adequate safeguarding policy, and we saw that when abuse of vulnerable adults was suspected, staff were aware of their duty to report this, and that safeguarding concerns were appropriately raised with the local authority.

The provider followed safe recruitment measures to ensure that staff were suitable for their roles, this included checking references and identification and carrying out appropriate pre-employment checks.

Medicines were administered by staff who had the skills and competencies to do this, however care plans were not always clear on who had this responsibility, and we found gaps in the recording of people's medicines which were not addressed by a suitable audit system.

The service had a detailed induction for staff and all staff received regular assessments on their skills and understanding in areas such as safeguarding adults, promoting dignity and administering medicines. Managers at the service provided leadership through regular supervisions and team meetings. Staff had regular training in order develop the appropriate skills to carry out their roles and systems were in place to ensure that training remained up to date.

We found breaches of the regulations relating to safe care and treatment and person-centred care. You can see what action we told the provider to take at the back of the full version of the 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?

Requires Improvement

The service was not safe in all areas. Risk assessments were in place to manage the risks to people, however these were not always reviewed adequately, and in one case there were insufficient measures in place to manage risks to an individual.

Medicines were not always recorded safely, and the service did not have adequate checks in place for detecting when errors were made in recording or administration. Staff had regular training on medicines administration and observations of their competency.

The buildings were kept secure and the provider carried out regular checks of safety. Staff were recruited in line with safer recruitment measures. The service was meeting its obligations in line with safeguarding adults.

Is the service effective?

Good

The service was effective. Staff underwent comprehensive training as part of their induction and on an on-going basis, and had assessments of their knowledge and skills.

People had consented to their care, and where they were not able to do so, the service had arranged for assessments of people's capacity and to attend meetings to ensure they were working in people's best interests.

People had health action plans, and support to attend medical appointments where necessary.

Is the service caring?

Good

The service was caring. People told us they felt well cared for and respected by staff. We observed friendly and respectful interactions. The service promoted people's choices, particularly through tenants meetings and ensuring care plans outlined people's choices and preferences.

There was a varied and interesting activities programme in place, including some innovative ideas in partnership with the local community.

The service promoted people's dignity through a yearly dignity challenge and by assessing and developing staff skills in this area.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive. At Donnybrook Court care plans were not adequate to meet people's needs. Summaries of people's care were undated and contradictory and it was unclear whether people's needs were being met. People were not receiving the allocated hours of care and reviews were not being carried out in a timely manner of people's care needs.

At Duncan Court care plans were detailed and up to date, and we saw that people's care was reviewed and people were receiving their agreed support hours.

People were aware of how to make complaints, and when people had complained we saw evidence that these were investigated and resolved in a timely manner and that people were happy with how the complaint had been addressed.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led. Managers at the service had extensive tools in place for monitoring the quality of the service. However, at Donnybrook Court these had not identified or addressed the shortfalls that we found.

The Provider had used tools such as induction, themed supervisions and regular assessments to ensure staff had the skills and values required to carry out their roles and to provide leadership. Team meetings were carried out regularly to allow areas for development to be addressed.

Creative Support - Donnybrook Court Extra 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 over three days, 15, 17 and 23 March, and was unannounced on the first day when we visited Donnybrook Court, and on subsequent days the service knew we were returning. On the second day we visited Duncan Court, and on the third day we returned to Donnybrook Court. The inspection was carried out by two inspectors on the first and second day, and a single inspector on the final day.

Prior to the inspection we looked at information the Care Quality Commission (CQC) held about the service. This included notifications of significant events sent to CQC since the service registered in February 2015.

In carrying out this inspection, we spoke to 13 people who used the service, three support workers two team leaders and the two site managers. We reviewed eight people's care records, including care plans, risk assessments and records of care received. We reviewed six staff files, including records of recruitment and supervision of staff, and other documents relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

The service was safe in some but not all respects. People who used the service told us they felt safe. One person told us "I feel safe here, the staff look after me."
People told us that staff helped them with their medicines and made sure that they had enough. We saw records which showed that medicines were ordered, checked, and where necessary returned to the pharmacy for disposal. Medicines were safely stored, at Duncan Court this was in people's flats in locked boxes. All staff who administered medicines had undertaken training on medicines, and had observations of their competency to administer medicines, which was reviewed yearly or in response to concerns from managers. At Duncan Court we noted one person was on a high dose of a painkiller which placed them at risk of dependency. This had not been reviewed recently by the person's GP. At Donnybrook Court, we saw that it was not always clear whether staff or the person's family were responsible for administering medicines. There were some gaps on medicines administration records (MAR) charts. Spot checks on people's medicines at Donnybrook were inconsistent and not being carried out in line with the service's policy, and did not always pick up on gaps in MAR charts. This meant there was a risk of the service failing to notice missed or wrongly administered medicines. The service had recently put a new system of auditing in place, but it was too early to say whether this was effective.
Risk assessments were carried out where it was identified that people may not be safe, such as addressing the risks of falling and those from smoking. Where people smoked in their flats, we saw that steps had been taken to manage the risks from this. However, not all risk assessments were in date, which meant there was a risk that they no longer met people's changing needs. We saw a risk assessment for a person who was at risk of choking when eating. Guidelines were in place in order to manage this risk, however the person ate unsupervised, and as they lived at Duncan Court there was a possibility that help would not reach them in time. Where risk assessments stated that people needed two staff to safely support them to bathe or make transfers, records did not show that this was always in place.
This amounted to a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had an effective safeguarding policy in place, and an agreed protocol with the local authority for reporting issues of concern. Staff we spoke with were all able to describe what safeguarding meant, the types of abuse and what they would do if they witnessed or were told about suspected abuse. Staff were aware of the whistleblowing policy, and told us if they had any concerns they would report this to a senior member of staff. Staff had all received safeguarding training, and we saw that managers in the service carried out yearly themed supervisions to test staff awareness in this area. Where concerns had been noted, we saw records that showed that these had been reported to the local authority and a notification sent to the Care Quality Commission, and the service had taken appropriate steps to address these concerns such as seeking medical attention and taking appropriate action to avoid a repetition.

Prior to this inspection, a fire safety enforcement notice had been served against the Provider in relation to Donnybrook Court. On the day of our visit, we spoke with a fire inspector, who confirmed that the service had taken appropriate steps to address these concerns. People who used the service had personal evacuation plans in the event of a fire, however these were missing for a small number of people at

Donnybrook Court. This had been picked up by a recent audit and the service was in the process of putting these in place. The service carried out daily checks to ensure that communal areas were clear and that fire exits were not obstructed. The landlords of the buildings carried out weekly checks of the fire alarms and emergency lighting. However, we did not see evidence that equipment such as assisted baths were checked regularly to ensure their safety.

Both buildings carried out daily checks of security, and were accessible via an intercom. CCTV was in place to monitor visitors to the buildings, which was visible from the main offices.

People had emergency pull cords, and where necessary pendant alarms in order to contact staff in the event of an emergency. People who used the service told us that staff responded quickly when they pulled the cords. These cords contacted handsets which were carried by managers and team leaders. There were areas of the building at Duncan Court where these handsets were out of range, however the service had programmed the alarm to go to an external call centre if calls were not responded to within three minutes.

Where people were supported to bathe, the service had taken steps to ensure that people were not scolded by hot water. The temperature of hot water was recorded by staff on a daily basis for each person, and in the event of water being too hot, this was reported to the landlord of the building. The landlord was carrying out weekly checks to reduce the risk of legionella from taps and showers in communal areas. However, these were not being carried out in vacant flats at Duncan Court, meaning there was a risk of legionella infection should people move into these flats. The provider took steps to address this during the course of our inspection.

Most staff had transferred from the previous provider. Staff records showed that they had been recruited in line with safer recruitment processes, and the service had records which confirmed people's identity and eligibility to work in the UK and where appropriate had confirmed this with the Home Office. The provider had checked for gaps in people's employment history and had two references on file for each staff member. All staff had undertaken a recent DBS check, and it was the provider's policy that these be repeated every three years. This meant that the risk of unsuitable staff working in the service had been reduced.

Where people received support with their finances, we saw that money handled by staff was recorded and safely stored. When staff had handled money, the balance was checked and signed by two staff, and regular audits were carried out on people's finances. This reduced the risk that people may be financially abused.

Good

Is the service effective?

Our findings

The service was effective. Staff told us they received good quality training sufficient to carry out their roles.

The provider had carried out a five day induction training programme for staff, this included areas such as dementia, nutrition and hydration. Records showed that staff had mandatory training in medicines, manual and people handling, first aid, infection control, food hygiene and health and safety. Staff told us that as part of their inductions they read the provider's policies and procedures, care plans and risk assessments and shadowed more experienced members of staff. At the end of people's inductions, they received an assessment of their knowledge and skills, which identified areas for further development. The service was working with Tower Hamlets Clinical Commissioning Group in order to attend an eight week course for dementia support for Extra Care Housing. This was initially being attended by managers, and the training co-ordinator told us they intended to provide this to all staff in due course.

The service had extensive measures for showing that people had consented to their care. This included signing their care plans and risk assessments, as well as completing consent forms to the gender of their care workers, and the level of support required with finances and medicines. A person told us "Staff always ask me if it is OK before they do things."

Where people might not have the capacity to consent to their care, we saw that the service had acted in line with the Mental Capacity Act. 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. The service had arranged for assessments of capacity where people may not have been able to make decisions for themselves, and had held meetings with social workers and the person's family in order to show that they were working in line with people's best interests. All staff had undertaken training in mental capacity as part of their induction training.

People usually prepared food in their own flats, where necessary with staff support. A person told us "I choose what I want to eat and staff cook it." Both buildings had arranged for people to have lunch together in the communal lounge when they wanted to. Staff had arranged for people to attend appointments with dietitians or the GP when there were concerns about their nutrition.

We saw evidence that people were supported to maintain good health. Every person's care plan contained an up to date health action plan, with an overview of their health needs and actions required to help them stay healthy. We saw records that showed that people were supported to see health professionals, both for routine appointments and that urgent or emergency care was sought when necessary.

Good

Is the service caring?

Our findings

The service was caring. People told us they felt respected and cared for by staff. People said "staff are good, kind and caring", "they help me with anything I want" and "we have a laugh and a joke."

The provider held regular meetings for people who used the service, which they used to discuss areas such as health and safety, security and activities. These meetings were used to obtain people's views on the service. We saw that people were supported to make choices about changes around the building, such as putting up curtains and buying fish to look after. A family forum had been started in January 2016, with the aim of making this a regular activity. The building at Donnybrook Court was in the course of being redecorated, and we saw that people's views had been taken into account, and everyone had had the opportunity to choose the colour of their front door.

The provider employed an activities co-ordinator, who worked with staff, volunteers and people who used the service to provide a varied and responsive programme of activities. The day before our inspection, Channel 4 News had visited Donnybrook Court to record a session with Furry Tales, an animal charity which brings in animals such as rabbits and hens for people to interact with. People were very positive about these sessions. We saw pictures of a mothers and babies group which had had a trial session in the service the previous week in order to promote social inclusion and provide an opportunity for people who used the service to interact with young children. Students from the Royal College of Music had recently carried out trial music sessions with people who lived at Donnybrook Court, we saw videos of people participating well in this activity. A group of young people from the YMCA had organised an afternoon tea as part of a community challenge project. These were innovative and very positive opportunities for people who took part in these sessions.

Donnybrook Court also had regular darts matches, active afternoons where people took part in exercises and games, and weekly music, manicure and bingo sessions. There were also sessions for crafts and games. Less regular activities included dementia awareness sessions, opera, and nights out to a jazz club.

Regular activities at Duncan Court included bingo, church services, active afternoons, afternoon teas, manicures and hand massage, arts and crafts and singing sessions, some of which were led by people who used the service. Special activities included Burns Night, Halloween, an Ascot Races themed session, visits from the Connaught Opera and dementia awareness evenings. We noted that staff had recorded people's birthdays on the staff calendar, so that these would not be overlooked.

People in Duncan Court were taking part in a project called It's My Life, in conjunction with the Dementia Occupational Therapy team at Mile End Hospital. We saw that people's life histories and likes and dislikes had been recorded, and people had had reminiscence sessions. The activities co-ordinator told us she hoped to use this information to inform future sessions. Both services also hosted parties on special occasions, including Christmas, Easter and VE Day. A local artist had attended the VE Day party, and had made a painting of the party for the service. People who used the service told us they enjoyed the parties. The activities programme at Donnybrook Court was more developed than that at Duncan Court, but the

service intended to continue to build more activities at Duncan Court.

We observed kind and respectful interactions between staff and the people they supported. People told us "the staff knock on my door and wait to be invited in". Support plans contained information on ensuring that people's choices were promoted and respected, and that people's independence had been maintained. The service had a yearly dignity challenge week, and as part of this had carried out themed supervisions for staff, where their understanding of promoting dignity and respect was assessed and areas for development identified.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to people's individual needs. For example, at Donnybroook Court we saw that care plans did not adequately detail people's changing needs. Summaries were in place of people's allocated support hours which broke down which tasks needed to be completed with people and at which times. However, we found that there were two summaries for each person, one for internal use and one for reporting back for the local authority which had commissioned the care. These documents contained discrepancies regarding the hours of support people received or the care that needed to be carried out, and contradicted the care plan. Care summaries were not dated, and it was unclear which document staff were using to deliver care. Logs of support showed that people were not receiving the hours they were commissioned to receive from the local authority, and as care plan summaries were inadequate we could not be certain that people's support needs were being met. We explained our concerns to the Registered Manager on the first day of our inspection, and when we returned on day three we saw evidence that the service had started to take steps to address these issues.

Memos to staff at Donnybrook Court showed that managers were aware that people needed to have reviews to ensure that their care plans were still adequate to meet their changing needs, and had started a process of carrying out reviews. At the time of our inspection, however, the service had carried out reviews for only 14 out of 40 people who used the service.

The above constitutes a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People at Donnybrook Court said "Staff come to help me, they are always on time", and "Staff talk to me about my care and how I want them to help me." One person said "Staff encourage me to do as much as I can for myself."

At Duncan Court we saw that care plans were regularly reviewed with people who used the service. Care plan summaries were in place for staff to follow when supporting people, These included a detailed breakdown of tasks which needed to be carried out, with information on people's preferences and how to promote the person's independence and dignity. Records of support provided to people showed that their needs were being met in line with these plans, and that they were in receipt of the hours agreed with the local authority. We found that there was a need for minor changes in a small number of these plans, for example some plans showed that the person needed staff to visit their flat to support with lunch, but the person was now choosing to eat downstairs.

We reviewed the file of a person at Duncan Court who had a hospital passport in place. A hospital passport is a document which gives useful information to hospital staff on the person's preferences and their preferred methods of communication during a hospital stay. However, this particular passport had not been reviewed since 2011 and their medicines had changed since this time. The manager told us that they would also give medicines administration record (MAR) charts to hospital staff in this eventuality, but there was a risk that as this document had not been reviewed that incorrect information would be passed to hospital

staff.

People who lived at Duncan Court told us "I get help when I need it, they always let me make choices for myself" and "I can't fault the staff with anything."

The service had an adequate policy in place for people to make complaints, which was clearly displayed in both buildings. People we spoke with were aware of how to make a complaint and felt comfortable raising concerns with staff and managers. Both services kept a detailed log of the complaints they had received, and what the service had done in order to address these. We saw evidence that complaints were addressed within the timescales outlined in the complaints policy and that the service had taken steps to investigate complaints and ensure that people who had complained were happy with how these had been resolved.

The service had extensive logs of compliments received from people and their families. These particularly related to the activities programme and the life story work the service had carried out with people.

Requires Improvement

Is the service well-led?

Our findings

The provider regularly carried out quality assurance audits around medicines, training, falls prevention, pressure care and moving and handling. However, at Donnybrook Court we saw evidence that audits and spot checks of medicines were not being carried out at a rate which would have identified errors in recording or administration that we found. Audits were in place for checking people's care plans and support hours, but these had only started in March 2016 and had not yet highlighted or addressed the shortfalls we found in people's care records.

At the time of our inspection, Donnybrook Court was the registered location for care being carried out at both sites. This means that we would expect to see that care was being managed from Donnybrook Court. However, records relating to the management of the service showed that both sites were being managed separately, with a separate manager responsible for each building, overseen by the area manager, who was currently the Registered Manager. We raised this with the Provider, who informed us that they intended to review the current registration arrangements for both buildings.

At Duncan Court we saw records which confirmed that checks of people's care were carried out within the identified timescales and that actions were taken to address any areas of concern. Staff told us, "The manager is very good, caring and supportive", and "The manager works closely with us to provide good care."

Managers at Duncan Court had carried out a customer satisfaction survey in February 2015 amongst people who used the service. Feedback from people was positive, with comments including "I enjoy the peace and quiet of living here" and "All the staff are very kind." Some issues had been identified, such as staff slamming doors and waking people up, and we saw records that showed that this had been addressed with staff.

Managers within the service demonstrated leadership in line with the provider's stated values. For example, we saw that staff received regular supervision from their managers which showed that staff had an opportunity to address any concerns, and that managers were able to give feedback about areas for development. The service had innovative themed supervisions, which took place in areas such as dignity, medicines and safeguarding adults. Records of these supervisions showed that staff skills and knowledge in these areas had been assessed and development needs identified.

The Provider had a detailed five day induction programme, which was provided for all staff, including those that had transferred from the previous provider. This showed that staff were inducted in the Provider's values and had had essential training in areas such as safeguarding, dementia, capacity, nutrition and hydration.

Team meetings were being carried out monthly on both sites. At Donnybrook Court, records showed that areas were addressed such as medicines policy, nutrition and hydration, reducing noise, and improving staff recording. At Duncan Court staff had discussed spot checks of files and medicines and had introduced a system of pull cord checks. Staff at Duncan Court had discussed life story work and had checked that

support hours were being delivered in line with people's agreed care plans. At both services, the provider had worked with the local authority to oversee the transfer from the previous provider and provide assurance to staff and people who used the service that people's hours would not be reduced as a result of the new contract.

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
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care was not always designed in a way that ensured that people's needs were met. Regulation 9(3)(b).

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care was not always provided in a safe way for people as the registered person was not doing all that was reasonably practicable to mitigate any risks to their health and safety. Regulation 12 (1)(b) Care was not always provided in a safe way for people as medicines were not always safely managed. Regulation 12(1)(g)