Real Life Options

Real Life Options - Lawrence House

Inspection report

1 Newhomes, Monyhull Hall Road
Birmingham
West Midlands
B30 3QF

Tel: 01214432034

Date of inspection visit:
21 March 2016
23 March 2016

Date of publication:
13 May 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 21 and 23 March 2016 and was unannounced. We last inspected the service in December 2013 and found it was complaint with all the regulations we looked at.

The service is registered to provide care for up to six people who have a learning disability or autistic spectrum disorder. At the time of our inspection there was not a registered manager in post. 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.

We found enough staff to cover people's basic needs but there was sometimes not enough suitably competent and experienced staff to accompany people to undertake activities in the local community, and this restricted people's choices. Some relatives, health care professionals and staff told us of concerns about the staffing arrangements.

Safeguarding procedures were available in the home and staff we spoke with knew to report any allegation or suspicion of abuse. All medication was administered by staff who were trained to do so but some aspects of medicines management needed improvement.

People could not be certain their rights in line with the Mental Capacity Act 2005 would be identified and upheld.

People were supported to maintain good health and to access appropriate support from health professionals where needed. People were supported to eat meals which they enjoyed and which met their needs in terms of nutrition and consistency.

People were at risk of infection as staff knowledge was lacking in some areas of infection control practice.

We saw that attention was needed to the environment. There had been some delays in carrying out repairs to the home but the provider was now taking action to address this.

People told us or indicated by gestures and their body language that they were happy at this home and this was confirmed by people's relatives. We observed some caring staff practice, and staff we spoke with demonstrated a positive regard for the people they were supporting.

Whilst we received positive feedback from staff about the manager it was evident that they had insufficient time to carry out all of their responsibilities to ensure that people received the support and care they needed. The manager was responsible for the management of four services but the provider had plans to reduce this to two.

It was not evident that arrangements for checking the safety and quality of the service by the registered provider were effective.

We found the provider was in breach of Regulations. 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 consistently safe.

People were not safely protected by appropriate deployment and adequate staffing levels to meet their needs. People were at risk of infection as staff knowledge was lacking in some areas of infection control practice.

Safeguarding procedures were available and staff we spoke with knew to report any allegation or suspicion of abuse.

Some aspects of medicines management needed improvement.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Not all staff had received training in topics that were relevant to ensure they safely met the needs of people using the service.

People could not be certain their rights in line with the Mental Capacity Act 2005 would be identified and upheld.

Is the service caring?

Good

The service was caring.

We saw good and kind interactions from staff towards people who lived in the home.

Staff spoke positively about the people they cared for. They knew people well and could tell us in detail about people's likes, dislikes and individual routines.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Arrangements for people to be able to participate in activities they enjoyed in the community needed to be improved.

Care plans and assessments did not always adequately guide

staff so that they could meet people's needs effectively.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were ineffective quality assurance systems in place to monitor all aspects of the home and in some instances had failed to address issues.

There was a manager in place but they were not registered. Relatives and staff said the manager was approachable and available to speak with if they had any concerns.

Real Life Options - Lawrence House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 21 and 23 March 2016 and was unannounced. The inspection was undertaken by two inspectors.

Before the inspection we looked at the information we already had about this provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any safeguarding matters. These help us to plan our inspection. The provider was asked to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We received information from a local authority that purchase the care on behalf of people, and we used this information to inform our inspection.

During our inspection we met with everyone who lived at Lawrence House. Some people's needs meant that they were unable to verbally tell us how they found living at the home. We observed how staff supported people throughout the day.

We spoke with the manager, care co-ordinator, two care staff, and an agency staff. We looked at parts of three people's care records, the medicine management processes and at records maintained about staffing, training and the quality of the service. We spoke with the relatives of three people who lived at Lawrence House and received information from three health and social care professionals.

Requires Improvement

Is the service safe?

Our findings

People who were able to speak with us confirmed that they did feel safe living in the home. We asked if there was anything at the home that frightened people and they said "No." Other people who were unable to express their views looked relaxed in the company of staff. Relatives we spoke with confirmed that they thought their family member were safe living at the home. A social worker told us that a person they had contact with was safe living at the home.

We looked at the staffing arrangements. Two of the three relatives we spoke with told us there were not always enough staff to meet people's needs. One relative told us "Sometimes there is tension between two of the people at the home and I do not think staff have the resources to manage this." A health care professional told us that two people at the home sometimes did not get on and this would be better managed if there were more staff available. Another health care professional told us that staffing levels were inadequate and this impacted on a person as they did not get the support they needed.
On the first day of our visit staff were very busy and did not always have time to provide us with the information we needed. Their priority was a person who was unwell. We saw that people in the home received appropriate support from the staff on duty and were not left waiting for assistance. We found our second day to be less hectic and staff had more time to spend with other people at the home and to assist in the inspection process. One person had a health appointment the day after our visit and we saw evidence that staffing levels had been increased for the day to facilitate attendance at this appointment. Most of the staff had worked at the home for several years and so knew people well. One person's relative told us, "Staff understand [person's needs, there is a good core of staff who know him well."

Staff rotas showed that in recent months there had been an increased use of agency staff. We were informed that this was to cover for staff annual leave. People who lived at the home had some complex needs including autism and were likely to find communication and relationships with numerous people difficult. The care co-ordinator acknowledged that the current use of agency staff was not ideal and that they tried to have some consistency with the agency staff they used. Staff told us that staffing arrangements sometimes had an impact on people being able to go out into the community as some people needed the support of two staff to do this. One member of staff told us that one person's increased behaviour episodes had coincided with a reduction in staffing levels at the home.

Safeguarding procedures were available in the home and staff we spoke with knew to report any allegation or suspicion of abuse. The provider had a whistleblowing hotline that staff could use to report any concerns. We noted there was information on display in the home regarding this so that staff knew who to contact if they had concerns.

Safeguarding alerts had been made when needed to the local authority and the Care Quality Commission had been notified by the service. We followed up on a recent incident and the care co-ordinator was able to demonstrate that some actions had been taken to reduce the risk of similar concerns occurring.

The manager and staff we spoke with confirmed that the necessary checks including references and a

Disclosure and Barring Service (DBS) check had been made before new staff started working at the service.

We looked at some of the fire safety arrangements that were in place. An agency staff confirmed they had been given an introduction to the fire procedures when they started work at the home. People had individual evacuation plans so that staff had information about the support they needed. We looked at the records for testing the fire alarms and saw these were done weekly but records indicated a fire drill had not been completed recently. This needed to be done to make sure staff knew how to support people to keep safe should a fire occur in the home.

We looked at the infection control arrangements. One person's relative told us that the home was always clean when they visited. We were made aware by staff that one person at the home currently had an infection. We saw that staff had implemented some additional infection control measures but staff did not have clear guidelines to follow. Discussions with staff showed they had not received adequate infection control training. The manager told us this was being arranged. We asked if the home had an infection control lead but was informed there was not one in place. We did not see evidence that staff had access to or were aware of the guidance document 'The code of practice on the prevention and control of infections' which tells care services what they should have in place to ensure good infection control.

We looked at the way medicines were stored, administered and recorded. The care co-ordinator and care staff told us that medicines were only administered by staff who were trained to do so and had been assessed as competent. There were suitable facilities for storing medicines. Some people were prescribed medication on an 'as required' basis and we saw that guidance was in place for staff about when this medication was needed. Most medication was in blister packs. The records of the administration of medicines were completed by staff to show that prescribed doses had been given to people. However in two instances we saw that the records had not been signed by staff. The medication was not in the blister pack therefore suggesting this medication had been given. One of these medications was for the day of our visit and staff confirmed they had given the medication but forgot to sign the record.

One person needed to have their medication administered in a particular way, otherwise there was a risk to their health. We brought to the attention of the care co-ordinator that only some of the person's medication records recorded how the medication should be administered. They told us they would ensure this was rectified.

We saw the supplying pharmacist had completed an audit of the medication system in November 2015. They had made some recommendations for improvement. We looked at some of these and found they had been actioned.

Requires Improvement

Is the service effective?

Our findings

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 to 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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

We observed that some people that lived at the home may not have had the mental capacity to make an informed choice about decisions in their lives. We found that there were coded locks fitted to external doors. These had been fitted recently following incidents of a person leaving the home without the support of staff. DoLS applications had previously been submitted to the local authority and we were informed that these would now be revisited following the recent installation of coded locks. We saw there were other restrictions on people moving freely about the home or having access to their belongings. Some people's bedroom doors or wardrobes were kept locked and they had not been provided with a key. Staff told us this was due to the behaviour of people and to protect their belongings. We did not see evidence to show there were any assessments completed to determine people's capacity to consent to these restrictions, and if the person was assessed as lacking capacity if any best interests decisions were in place for these practices. Whilst staff had received training in the MCA and DoLS the day to day practice of staff showed this had not been fully understood.

The provider was not ensuring that people's rights were protected and this was a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 11.

All staff undertook an induction at the start of their employment with the service. New staff spent time shadowing more experienced members of staff to help them get to know the people they would be supporting. An agency member of staff told us that when they started working at the home they were told about the fire procedures, were given information about people's needs and that staff observed their practice. They told us they had not worked on their own with people until they had completed four shifts.

We asked staff about the training they had received. The staff we spoke with did not raise any concerns about the training on offer but training records did not show staff had received training in all of the areas needed to support people. For example we were informed that one person at the home had autism but few staff had received training in this. The majority of staff had also not received training in infection control. Some people at the home had a specific health condition. We were informed that the majority of staff had completed training in these areas but this was not supported by the training records we saw. During our visit the care co-ordinator liaised with a health care professional to make arrangements for some specific

training for staff.

We looked at the supervision arrangements for staff. The staff we spoke with confirmed they had received recent supervision and felt supported in their roles. One care staff commented that supervision was not always regular but that they could approach the manager at any time. Supervision is an important tool which helps to ensure staff receive the guidance required to develop their skills and understand their role and responsibilities.

There had been recent staff meetings at which staff discussed people's care, staff responsibilities and plans for the future. The manager undertook formal observations of staff practice, for example when staff were supporting people with an activity. The observation resulted in a formal score for the engagement observed and this was discussed with the staff this enabled staff to reflect on their practice and identify possible improvements.

We observed sufficient drinks being offered to people throughout the day. We observed people being assisted during a meal. People received appropriate support and their facial expressions indicated they were enjoying their meals. People who were able to communicate with us confirmed they were happy with the meals provided. One person's relative told us, "I have no problems with the food, there is always plenty to eat." People's care records contained information for staff on people's nutritional needs and the textures they required for meals and drinks. We saw that people were given meals and drinks in line with their recorded guidance. Staff told us that the menus were completed on a weekly basis following consultation with people who lived at the home. One care staff told us, "We do the menu's every Sunday with people, we use pictures of meals and they each pick a meal."

We found evidence that people had been supported to attend a range of health related appointments in relation to their routine and specialist needs. We saw that people attended appointments at hospitals and the GP surgery as well as receiving regular dental and optical checks. The relatives of people living at the home told us that their family member's health care needs were met. One relative told us, "They meet [person's name] health care needs, they are always taking him to appointments." Another relative told us, "Healthcare needs, staff deal with these, they are never neglected." A healthcare professional confirmed to us that staff met the healthcare needs of the person they visited.

Some people had health conditions that may require staff to seek emergency assistance from health professionals. Whilst staff were able to describe to describe the actions they would follow to keep the person safe the information was not always consistent with the information in the person's care plan. One person had recently been unwell and we saw evidence that staff had contacted their GP regarding this. Another person was due to visit the GP during our visit. We saw that staff took the time to explain to the person why they were going. The person told us he was in pain and that staff were looking after him.

Good

Is the service caring?

Our findings

People who were able to communicate with us confirmed that staff were caring. One person told us that the staff were "nice." The relatives of people who lived at the home confirmed that staff were kind and caring in their approach to people. One relative told us, "The staff are all excellent, they really care for [person's name]. Another relative told us, "The staff are all caring, they are brilliant. They all try their hardest." Two health professional told us that staff all really cared about the people they supported.

People told us they were supported to maintain relationships with people that mattered to them. One person told us they were supported by staff to telephone one of their relatives every week. People's relatives confirmed the staff were always friendly and polite and welcomed them in to the home to visit their family member. One care staff gave examples of how they supported a person to remain in contact with relatives by writing and sending cards and pictures. One person's relative told us how they working with staff to help organise a birthday party for their family member.

One person had been unwell and we saw that care co-ordinator manager and staff checked on their well-being frequently during our visit. Staff demonstrated a genuine concern for how the person was feeling. Another person complained of being in pain and we saw staff took the time to sit with them and offer support. Some staff told us about a person who had been in hospital and that they had visited the person in their own time. This demonstrated staff had a caring attitude towards people.

Opportunities were available for people to take part in everyday living skills, for example involvement in shopping for food and household items. We saw that staff prompted people to carry out tasks needed rather than to do things for them. This helped to maintain their independence.

We asked care staff what they did to protect people's dignity and privacy and all the staff we spoke with were able to describe how they did this. We saw examples of this including staff knocking on people's bedroom doors and seeking permission to enter. People's care plans gave staff about how their personal preferences, for example one person liked to be left in private whilst they dressed. On the first day of our visits we saw that there was some personal information about people on display in the dining room. This did not respect people's confidentiality. We brought this to the attention of the care co-ordinator and saw that this had been addressed on the second day of our visit.

We saw that people were dressed in individual styles of clothing reflecting their age, gender and the weather conditions. People were well presented and looked well cared for. One person signed to us that staff were going to help them have a shave later, even though they already appeared clean shaven. Staff told us that the person always liked to have two shaves a day. This showed that staff recognised the importance of people's personal appearance and this respected people's dignity.

Requires Improvement

Is the service responsive?

Our findings

Each person had a care plan to tell staff about their needs and how any risks should be managed. Care plans recorded people's likes and dislikes, what was important to them and how staff should support them. We saw that for each person there was a vast amount of care plans and risk assessments in place, and much of the information was duplicated. Due to the large quantity of written information this made it difficult for staff to have the time to read and be aware of all of the information and any changes in need.

We saw that care plans had been regularly reviewed but these did not always show that where appropriate, people's relatives had been involved or consulted with to ascertain if there were changes needed. However a relative we spoke with confirmed they were included in care plans and review meetings.

We looked at the arrangements in place for people to participate in leisure pursuits and activities they enjoyed. We saw limited activities and stimulation being offered on the days of the inspection due to staff time being focussed on a person who was unwell. One person spent time doing a jigsaw. Another person undertook an art activity supported by a care staff, the person told us this was something they enjoyed doing.

One person's relative told us that their only concern about the home was that there were not enough staff to enable the person to go out regularly. They told us, "He gets bored." Another relative told us, [Person's name] does not get out much, it is spasmodic. He does not get enough stimulation." A health care professional told us that the person they supported did not have sufficient opportunities to access the community. Another health care professional told us a person spent most of their time doing jigsaws as there was a lack of meaningful activities. Staff told us that staffing arrangements sometimes had an impact on people being able to go out into the community as they needed staff support to do this. People's records showed that they liked to participate in a range of activities including outings to places of interest but our observations and records showed that they spent most of their time at home. This was a concern as staff and records we viewed indicated that some people's behaviours was known to escalate if they did not have enough activities.

The manager acknowledged that people were not always able to go out on activities as often as they wanted due to staffing levels. We were told that to try and reduce the impact on people that external organisations and individuals visited the home to provide music and massage therapy.

We saw that regular 'house meetings' were held with people who lived at the home. As part of these meetings staff made sure they explained to people who they needed to tell if they were unhappy about something. The relatives of people living at the home told us they were confident to raise any concerns or complaints directly with the manager. The manager told us that one complaint had been received. We saw this had been responded to and an apology given.

There was information for people about how to make a complaint about the service but this was on display in the staff office and not in a communal area and so it may not be easily visible for people and visitors.

Although the information was in an easier to read format that included pictures it contained out of date information to include the name of a previous manager of the home. This meant there was a risk that people and relatives would not know how to make a formal complaint or who to contact.

Requires Improvement

Is the service well-led?

Our findings

Our inspection found that the governance of the home had been ineffective. The registered provider had not provided the required additional support, resources or monitoring to ensure that a good quality service was being provided.

Some records were not available or up to date during our visit. This included staff training and recruitment records. Some information was updated and sent to us after the first day of our visit. We asked to look at records of recent staff meetings, minutes of the last meeting were available but the care co-ordinator could not locate the minutes of other recent meetings. We asked to look at the guidelines for one person's specific health need. We were informed that this was not available as it been taken to the hospital with the person and the hospital had mislaid this. This did not show that data protection issues had been fully considered. We were informed that a copy of the information had not been made before it was given to hospital staff.

We saw that records of incidents in the home were not being maintained. The incident log did not record an incident of a person leaving the home and behaviour incidents of a person damaging property in the home had not been recorded. An analysis of the incidents of damage to the environment had not been completed. This meant there had been a missed opportunity to identify ways of reducing the risk of this occurring. The provider had failed to set up systems to review or monitor any incidents and accidents or use information they gained to analyse trends which could prevent the likelihood of negative experiences for people recurring.

Staff told us that damage to the environment had been caused by a person living at the home. They told us that previous damage to hallway floors and the radiators had been repaired but we saw that damage to the kitchen, a window, wallpaper coverings and a bathroom had not yet been repaired. The bathroom was not in a useable condition and so people only had the option of using the shower. The bathroom had been out of action for six months. During our visit there was a contractor in the home who we were told was doing an estimate for the repairs to be completed. We were informed that the provider was liaising with the landlord in regard to the repairs needed. Whilst it was positive that some actions were now being undertaken to schedule this work it was disappointing that there had been a delay to this and that people had had to live in an environment that had not been well maintained. We received some conflicting information about why the repairs had been delayed however some staff told us this was due to the likelihood of a person damaging areas that had been repaired as this was a known behaviour. Given the lack of incident records completed we were unable to verify the accuracy of this information.

The provider had not undertaken recent checks to assure themselves that the service was providing effective, caring, responsive and well- led care. They had completed an audit in July 2015 to check if the service was safe. We saw there were some issues identified from this audit that had still not been addressed. This included making sure the complaints procedure was up to date and accessible and ensuring a fire drill was completed. The audit also identified that incident records were not being used to analysis a person's behaviour to establish if they were increasing or if the behaviour support plan needed to be amended. We were not shown any evidence to show that the provider had checked to make sure the issues identified in

their audit had been rectified and from our inspection it was clear that many of the issues still remained. This meant that the provider had not ensured there were there were effective systems in place to monitor the quality and safety of the home and to identify and address risks or any areas of concern.

These issues regarding governance and oversight of the service were a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 17.

A relative told us that they had not received any surveys to seek their views about the quality of the service provided. This meant that opportunities had been missed to gather and look at feedback to see if any action was needed to improve the quality of the services provided.

Lawrence House had a manager in post but they were not registered. The relatives of people living at the home told us that both the manager and the care co-ordinator were approachable. One relative told us, "The manager is approachable and the care co-ordinator is excellent." A care staff told us, "They are both approachable. I am confident to raise issues. I have raised things and they have dealt with."

In addition to managing Lawrence House the manager was also responsible for three other services, all within walking distance of each other. During our visits the manager was only able to spend a limited amount of time with us as they had meetings and other commitments for other services. One person's relative told us, "I think the manager is too thinly stretched, I don't feel confident that things will always get done." A health professional told us that because the manager had other homes to manager they were not able to invest their time at Lawrence House. Staff we spoke with told us the manager usually visited the home on a daily basis and was available by telephone when needed. We have been made aware by the registered provider that consideration is being to reducing the number of services that the manager is responsible for.

The registered provider had made us and the relatives of people at the home aware that there were proposals to change the type of service to supported living. At the time of our inspection we had not received any application for this. Some relatives were concerned about the proposal and the effect this may have on people. One relative told us, "It has not really been explained to us about what this will all mean." The provider had written to relatives in March 2016 outlining proposals for their services in Birmingham and this outlined that they intended to provide more details and opportunities to discuss the proposals.

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 11 HSCA RA Regulations 2014 Need for consent The provider was not ensuring that people's rights were protected and this was a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 11.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The absence of effective systems and processes to ensure that the provider could ensure that compliance with the regulations could be achieved failed to ensure that health, safety and welfare of people using the services was assured. (17(1) (2)(a) (b) (d) (e) and (f))