Galaxy Management Solutions Limited

# Morning Stars

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection took place on 05 February 2019 and was unannounced. At the last inspection completed in August 2017 we found the service to be rated as 'requires improvement'. We also found the provider was not meeting the regulations around providing good governance of the service. At this inspection we found the provider continued not to meet this regulation and remained rated as 'requires improvement'.

Morning Stars accommodates up to 20 people who have been diagnosed with one or more mental health conditions. At the time of our inspection there were 18 people living in the service.

There was 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.

People were not protected by robust safeguarding systems that ensured all relevant concerns about people living at the service were reported to the local safeguarding authority.

People were not supported by care staff who understood how to uphold their rights through the effective use of the Mental Capacity Act 2005 (MCA). People were not supported by staff whose training was consistently effective and always gave them the skills and knowledge required.

People were not supported in a consistently caring way. While some interactions were kind and caring and positive examples were seen, we saw other interactions that indicated care staff were not consistent with this support. People's independence needed to be promoted further and improvements needed to be made to how people's privacy and dignity was respcted and upheld.

People did not always feel heard and that their concerns were listened to and acted upon. The registered manager had developed quality assurance and governance systems although these were not effective in identifying the areas of improvement required within the service.

People were supported by care staff who understood how to minimise the risk of harm such as injury to themselves. Risks associated with behaviours that could challenge others were managed effectively. People were supported by sufficient numbers of care staff who were recruited safely. People received their medicines as prescribed.

People enjoyed the food and drink they received. People had access to a range of healthcare professionals and appropriate support was provided to enable people to access healthcare services.

People had access to leisure opportunities and activities although this was limited. Improvements were needed in the range of opportunities available to people that met their own individual needs and

preferences.

We found the provider was not meeting the regulations around safeguarding people, dignity and respect and good governance. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

## 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 protected by robust safeguarding systems. People were supported by care staff who understood how to minimise the risk of harm such as injury to themselves.

People were supported by sufficient numbers of care staff who were recruited safely. People received their medicines as prescribed.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

People rights were not upheld by the effective use of the Mental Capacity Act 2005 (MCA). People were not supported by staff whose training was consistently effective and always gave them the skills and knowledge required.

People enjoyed the food and drink they received. People had access to a range of healthcare professionals and appropriate support was provided to enable people to access healthcare services.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

People were not supported in a consistently caring way.

People's independence was not always promoted and people's privacy and dignity was not always respected and upheld.

### Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

People had access to leisure opportunities and activities,

although this was limited and not reflective of their individual interests and lifestyle choices.

People did not always feel heard and that their concerns were listened to and acted upon.

## Is the service well-led?

**Inadequate**

The service was not consistently well-led.

The registered manager had developed quality assurance and governance systems although these were not effective in identifying the areas of improvement required within the service. Action was not always taken in response to people's feedback.

# Morning Stars

**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 05 February 2019 and was unannounced. The inspection team consisted of two inspectors and one assistant inspector.

As part of the inspection we reviewed the information we held about the service. We looked to see if statutory notifications had been sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. We sought information and views from health and social care professionals. We also reviewed information that had been sent to us by the public. We used this information to help us plan our inspection.

During the inspection we spoke with four people who used the service. We spoke with the registered manager, a team leader and four members of staff including the cook and care staff. We also spoke with a director of the company that owns the service and two health and social care professionals. To help us understand the experiences of people we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people living at the service. We also carried out observations across the service regarding the quality of care people received. We reviewed records relating to people's medicines, five people's care records and records relating to the management of the service; including recruitment records, complaints and quality assurance records.

Requires Improvement

# Is the service safe?

## Our findings

At the last inspection completed in August 2017 we rated the provider as 'requires improvement' in this key question. At this inspection we found while the provider had made some improvements in certain areas, they had not improved sufficiently overall and remained 'requires improvement'. They were also now in breach of the regulation around safeguarding people from harm.

People told us they felt safe living at the service. Care staff we spoke with were able to describe signs of potential abuse and how they would report concerns about people. We saw positive examples of where concerns about people had been reported to the local safeguarding authority. This ensured appropriate investigations were completed and plans put in place where necessary to protect people from further harm. However, we found the provider had failed to develop systems to ensure concerns were consistently identified and reported where appropriate. For example; we found one person who was legally restricted from leaving the service alone in order to protect them from harm, had left alone and was missing for a period of time. The provider had located the individual; however, they had not followed their own internal policy and other agencies had not been notified. This included the police, the local safeguarding authority or CQC. Following this incident, robust plans had not been developed to ensure this person was protected from further harm. The registered manager also told us they felt the person was safe and able to leave the service alone, despite them being assessed by the local authority as unsafe to leave without support of care staff.

We found where care staff reported incidents in daily care records when people demonstrated behaviours that could harm others, these were not always reported to or identified by the registered manager. As a result, the concerns were not reported to the appropriate agencies, including the local safeguarding authority, investigations were not completed and plans were not put in place to protect people from the risk of ongoing harm. The registered manager had not ensured that the knowledge of care staff around the requirements of safeguarding was sufficient. As a result, issues were not always recognised and reported and appropriate action was not taken to protect people from the risk of ongoing harm.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding people who use services from abuse

We found the risks associated with behaviours that could challenge were being managed well, resulting in low numbers of incidents that could cause potential harm to others. We found the environment within the service to be calm and relaxed. Care staff understood how to protect people from the risk of injury and the registered manager had developed a system to learn lessons from significant events both inside the service and externally. For example, they had changed systems around serving food to reduce safeguarding incidents. They had also used learning from the Grenfell tower fire to review fire safety processes within the service.

People were protected by adequate infection control processes. We found the service to appear clean and saw weekly cleaning checks were in place. Care staff were aware of infection control procedures and

personal protective equipment (PPE) was made available for staff members where required.

People received their medicines as prescribed. The provider had safe systems in place to manage people's medicines. We found medicines in the service were stored safely and securely. The amount of medicine in stock matched the amount outlined on people's medicines administration records (MAR). Where concerns were identified around people's medicines, the provider had asked people's doctors to review their medicines to ensure any required changes could be made.

People were supported by sufficient numbers of care staff in order to protect them from harm. Care staff had been recruited safely. Pre-employment checks were completed prior to care staff starting work at the service. This included identity, reference and Disclosure and Barring Service (DBS) checks. DBS checks enable employers to view potential staff members' criminal history to ensure they are suitable to work with vulnerable people.

Requires Improvement

# Is the service effective?

## Our findings

At the last inspection completed in August 2017 the provider was found to be 'requires improvement' in this key question. At this inspection we found while the provider had made some improvements in certain areas, they had not improved sufficiently overall and remained 'requires improvement'.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

We found where people had capacity to make decisions or provide consent, they were supported to do this. Where people lacked mental capacity, the requirements of the MCA were not always fully understood by the registered manager and care staff. Care staff we spoke with understood some of the basic principles of the Act and where it was felt people lacked capacity, meetings were held with the person and a range of appropriate professionals to make decisions in the person's 'best interests'. However, we found neither the registered manager nor care staff understood how to ensure people's capacity was assessed in accordance with the legislation using the 'two stage capacity test'. This is the process outlined by the law that is required to test if someone does not have capacity to make a specific decision. We also found the registered manager and staff team had insufficient knowledge around the requirements of the Deprivation of Liberty Safeguards (DoLS) and when these were applicable. This included what action they should take if incidents arose that affected people being restricted by DoLS.

People were not supported to live in an environment that was well maintained and comfortable. We found the use of the building was 'institutionalised' in places; for example, with the use of a 'hatch' to administer people's medicines through. Some of the furnishing people were expected to use were not well maintained; for example, sofas were seen to be threadbare and needed replacement.

People told us they were happy with the food they ate. One person told us, "I am happy with the food and drinks. We get choices in the food and drinks." We found the cook provided a range of options for people based on their knowledge of people's preferences, including any cultural preferences. People were given access to drinks and snacks during the day. We did however find that people could be more proactively involved in designing menus. We also found steps could be taken to enable people to access food and refreshments more independently throughout the day. The registered manager felt they were already taking appropriate steps to facilitate this.

People were supported by care staff who received regular training and supervision. The registered manager

produced personal development plans for each member of staff. They provided additional support to care staff where areas of concern were identified in their practice and also took disciplinary action where appropriate. We found care staff had access to regular training although this training was not always effective. For example, care staff did not have effective knowledge around the Mental Capacity Act 2005 (MCA) despite them having recently received training in this area. Staff did however tell us they felt supported in their roles.

People were supported to access a range of healthcare professionals including the community psychiatric nurse, doctors, dentists and chiropodists. We found some positive work had been completed supporting people with anxieties around attending medical appointments. This had resulted in people accessing support when they may otherwise not have done so. We received positive feedback from one healthcare professional around the working relationship developed with the service which led to positive outcomes for people. We found where concerns were identified about people's health, support from appropriate professionals was sought. However, some aspects of healthcare monitoring could be improved. For example, the doctor of a person living with diabetes had recommended regular weight monitoring and this had not been done.

Requires Improvement

# Is the service caring?

## Our findings

At the last inspection completed in August 2017 the provider was found to be 'requires improvement' in this key question. At this inspection we found while the provider had made some improvements in certain areas, they had not improved sufficiently overall and remained 'requires improvement'.

Most people told us they were happy with their care staff, although some people told us they did not always feel heard. For example, one person told us they did not like being woken up by care staff when they were asleep. They said this continued to happen even through they had told staff they wished to be left to wake up naturally. We saw multiple examples of warm, friendly interactions between people and care staff supporting them. However, this was not always consistent and we did see some examples where care staff were not always kind and caring in their approach. For example, we saw one member of care staff answering someone in an abrupt way when they asked for a drink. We also found care staff did not always use language that was respectful and dignified when speaking about people. One member of staff referred to people as, "naughty" when they were describing behaviours that could challenge others or indicated distress.

People told us staff respected their privacy and dignity. One person told us care staff respected their room as being their own personal space and said, "They ask me before going into my bedroom if I am downstairs." Care staff told us they would always knock before entering people's rooms, but again we saw this was not consistent. We saw one member of care staff walked into someone's room without knocking and without checking they were not in the room first. We saw the process for administering medicines could be improved to make this more dignified and caring. People attended a 'hatch' in order to be given their medicines, which was not a person-centred, dignified practice. The interactions between care staff and people during medicines administration were functional rather than being warm and caring.

We found these inconsistencies were present across the service. For example, people's independence was promoted well in some ways, but not in others. Where people were able to, they were supported to go out in the community either by themselves or with care staff, as appropriate to their individual needs. However, we saw people could be encouraged to do more independently within the home. People told us they had to ask staff for a drink if they were thirsty if it was not within allocated times, rather than facilities being made available and risk assessed to encourage people to do this for themselves. Also, people and care staff told us care staff completed people's laundry for them, rather than supporting people to do this for themselves wherever possible.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Dignity and respect

We saw more could be done within the service to make it a 'homely' environment for people, encourage their participation and involvement and promote choice. The registered manager had basic expectations of care staff around the choices they offered to people and how they promoted independence. For example, we saw the registered manager had identified in a quality assurance document that allowing people to

choose if the TV was on or off was a positive outcome for them, rather then recognising this as a basic right. We saw more could be done to promote choice in the environment.

Requires Improvement

# Is the service responsive?

## Our findings

At the last inspection completed in August 2017 the provider was found to be 'requires improvement' in this key question. At this inspection we found while the provider had made some improvements in certain areas, they had not improved sufficiently overall and remained 'requires improvement'.

People gave us mixed views around the leisure opportunities and activities they could participate in. Some people told us they were able to go out and about when they wanted to, but others said they were 'bored' in the service. Where people did go out they enjoyed the time they spent with care staff. One person told us, "I go shopping with [staff member's name], I enjoy it. She's a real fun lady."We saw people had access to some leisure activities such as Zumba and colouring, but further opportunities were very limited. We saw the registered manager promoted special events and got involved in initiatives such as, 'Live Music in Care'. However, there was insufficient work done to identify people's individual needs in relation to leisure opportunities and how they may want to engage in more basic day to day activities. Where individual needs had identified certain activities may be beneficial, care records indicated this was not always done regularly and consistently. This mirrored our observations during inspection and what people told us.

We saw care plans were in place that outlined people's individual needs. The registered manager had developed good relationships with healthcare professionals which meant people's changing needs were responded to. Where health concerns were identified, these were understood and the registered manager worked well with healthcare professionals to ensure the right support was given to people. We saw care plans were reviewed regularly and were updated where required. We found care plans however did not always contain detailed information about how to meet people's emotional needs or their needs in relation to their sexuality or cultural preferences.

We found people within the service did not specifically require end of life care plans. However, one person had recently been taken unwell and had passed away. The registered manager responded well to this situation and ensured appropriate support was in place for this person during the final days of their life.

People gave us mixed views around how able they felt to approach care staff in the event they needed to share a complaint or concern about the service. One person told us, "If something goes wrong I am able to approach staff". Another person told us they did not feel staff listened to them when they had raised issues or concerns. The registered manager told us only one complaint had been received into the service which had been responded to appropriately. However, this did not match what we were told by people. People shared concerns with us such as not enjoying standing in the rain outside when they had a cigarette. These concerns had not been identified by the registered manager and action had not been taken to respond to, or resolve these issues.

Inadequate

# Is the service well-led?

## Our findings

At the last inspection completed in August 2017 the provider was found to be 'requires improvement' in this key question. They were not meeting the regulation around providing effective governance of the service. At this inspection we found while the provider had made some improvements in certain areas, they had not improved sufficiently overall and improvements were still required. They had failed to ensure that effective quality assurance processes were in place and remained not meeting the regulation around the effective governance of the service.

We looked at how the registered manager was assessing the quality of the service provision and identifying areas of risk within the service that needed to be addressed. We saw the registered manager had developed quality assurance systems, but they remained ineffective. They were not identifying areas of improvement required within the service and were not effectively benchmarking the service against national guidance and standards.

We found the registered manager had not ensured they consistently adhered to the provider's policies and procedures. We found one person had been 'missing' for a period of time. The staff team conducted a search of the premises and local area, but had failed to follow steps outlined in the provider's policy for this type of event. This included notifying the local police. The provider had failed to alert any authority of this incident despite the person being under a Deprivation of Liberty Safeguard (DoLS) which restricted them from leaving the service alone in order to protect their personal safety.

We found the registered manager had not developed sufficient monitoring systems within the service. For example; the temperature of the room in which medicines were stored was not being monitored. Monitoring the temperature is important to ensure medicines are stored correctly and remain effective. We also found documents and records relating to people's care were not being monitored to identify any errors or issues. One record outlined a person had lost a significant amount of weight over a prolonged period of time. Care staff and the registered manager were not aware of the reasons for the weight loss, and no record was in place that confirmed the weight loss had been identified and the reasons for it explored. With the person's consent, their weight was checked during the inspection to confirm they were no longer at risk. However, the registered manager's systems were not able to confirm this prior to our intervention. We found further issues with records, including the lack of documented plans around maintenance and redecoration of the service. We found areas in the service requiring work and development; including sofas in lounge areas which were very worn and thread bare. This was not identified in any formal plans although the registered manager provided assurances this was being addressed.

The registered manager had developed a system where they assessed the performance of the service against CQC's five key questions and key lines of enquiry. We found the registered manager had not effectively critiqued the service and identified areas in which they could improve. The registered manager's assessment was that the service was good with areas of outstanding practice. They had not used this review of the service to identify areas of improvement to ensure the quality of the service overall was improved for the people living there. The registered manager had not identified that some aspects of care delivery was

not person-centred, care staff were not always demonstrating a caring, respectful approach and that people were not always given sufficient opportunity to engage in meaningful activities. The registered manager had also failed to ensure that staff were fully competent in all aspects of their role; including recognising and reporting incidents. The registered manager had not developed an action plan that evidenced they had identified areas in which they needed to improve and what action was being taken in order to achieve this.

The registered manager had also not ensured people's feedback had been proactively sought. They told us that people did not have any concerns or complaints at the time of the inspection. However, this did not match what people told us. People shared concerns because they did not always feel their voices were heard or listened to. Issues they said they had shared included not wanting to be woken up and not standing outside when it rained to smoke, but no action had been taken to address these concerns. One person told us they felt brushed aside if they tried to raise any issues or concerns. The registered manager had failed to ensure that effective systems to seek people's views and feedback were in place.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

We found the registered manager and provider had  not submitted all required statutory notifications to CQC. We found significant events had arisen and the registered manager had not submitted the relevant notification as required by law.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Notifications of other incidents

We saw the registered manager had a good rapport with people in the service. We saw positive relationships were in place and people felt comfortable approaching the registered manager and other care staff within the service. People did however tell us they did not always feel their views were heard. Care staff told us they felt well supported by the registered manager and they were able to share any issues or concerns. Care staff attended regular staff meetings at which any areas for improvement were discussed.