Care Management Group Limited

Care Management Group - 16 Hawthorn Crescent

Inspection report

16 Hawthorn Crescent
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 29 March 2016 and was an unannounced inspection.

Care Management Group - 16 Hawthorn Crescent is a residential care home that provides care and support to a maximum of four people who have learning and physical disabilities. The home is situated in a residential area of Worthing, adjacent to another service run by the provider. The two services share a garden and minibus. At the time of this inspection there were four young adults living there.

The service did not have a registered manager in post. Although the registered manager had left, they had not yet applied to deregister with the Commission. A new manager had started in post at the end of October 2015 and was in the process of registering with us. 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 did not always receive safe care and treatment because recorded information on risks to their health was not always consistent and staff lacked guidance on how to mitigate known risks in relation to constipation.

People received their medicines safely, but some liquid medicines and creams had not been dated on opening. This was quickly addressed before we left the service.

People felt safe at the home. There were enough staff with the skills and experience to support people safely. Pre-employment checks were completed before new staff began work. All of the staff we spoke with told us they enjoyed their work and felt well-supported by the manager.

Staff knew people well and helped them to make decisions relating to their care and support. We observed staff took time to discuss options with people and respected their wishes. Staff understood how people's capacity should be considered and had taken steps to ensure that their rights were protected in line with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). People were involved in deciding the menu and getting the weekly shop. Each person was supported to eat a healthy and balanced diet that reflected their individual needs. The manager had ensured that people had access to regular healthcare support such as the dentist and chiropodist.

People were involved in determining the support they received and worked closely with their keyworkers to make plans for future activities and goals they wished to achieve. Staff took prompt action when there were changes in a person's support needs or behaviour. There were also plans to make improvements to the premises, such as installing a new kitchen, to make it easier for people to participate in everyday tasks. There were regular residents' meetings where people were able to share ideas and make suggestions. There was a friendly and upbeat atmosphere at the service. The manager and staff team were approachable and

people told us they could speak up if they were worried.

The manager and provider had a system to monitor and review the quality of care delivered and the safety of the service. Where improvements had been identified, action plans were in place and demonstrated that audits had been used effectively to make improvements to the quality and safety of the service.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of 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 at risk of harm because information on the risks to their health and safety and on how to mitigate them was not always consistent or sufficient.

There were enough staff to meet people's needs and keep them safe. Pre-employment checks had been completed for new staff before they started work.

People said they felt safe. Staff were trained in safeguarding so they could recognise the signs of abuse and knew what action to take.

Medicines were administered safely.

Is the service effective?

Good

The service was effective.

Staff were knowledgeable about people's care needs. They had received training to carry out their roles and received regular support and supervision.

Staff understood how consent should be considered and supported people's rights under the Mental Capacity Act.

People could choose their food and drink and were supported to maintain a healthy diet.

People had access to healthcare professionals to maintain good health.

Is the service caring?

Good

The service was caring.

People received person-centred care from regular staff who knew them well and cared about them.

People were involved in making decisions relating to their care

and were encouraged to pursue their independence.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People received personalised care that met their needs.

People were involved in activities that interested them and were supported by staff to achieve individual goals.

People were able to share their experiences and were confident they would receive a quick response to any concerns.

Is the service well-led?

Good

The service was well-led.

The culture of the service was open and positive. People and staff felt able to share ideas or concerns with the manager.

The manager was new in post and had already made significant progress in addressing the areas for improvement identified through recent audits.

The manager and provider used a series of audits to monitor the delivery of care that people received and to monitor progress.

Care Management Group - 16 Hawthorn Crescent

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 29 March 2016 and was unannounced.

One inspector undertook this inspection.

Before the inspection, we reviewed two previous inspection reports and notifications received from the service before the inspection. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care throughout the day and during preparations for the evening meal. We looked at care records for two people, medication administration records (MAR), monitoring records, accident and activity records. We also looked at three staff files, staff training and supervision records, staff rotas, the staff communication book, quality feedback surveys, audits and minutes of meetings.

During our inspection, we met with the four people who used the service and spoke in detail with two. We also spoke with the manager, the acting deputy manager, one shift leader, two support workers and a representative of the provider.

The service was last inspected in December 2013 and there were no concerns.

Requires Improvement

Is the service safe?

Our findings

Risks to people's wellbeing and safety had not always been effectively mitigated. We found that bowel monitoring records contained gaps and that there was a lack of guidance on how to administer laxatives prescribed to reduce the risk of constipation. One person was prescribed a laxative on an 'as required' basis. The guidance for staff on when to administer it stated only that it was for 'Constipation' but gave no indication as to the person's usual pattern of bowel movements or when staff should be concerned. The bowel monitoring charts for February and March 2016 contained gaps where no record had been made. The records in place indicated that the person had gone seven days without a bowel movement in February and six days in March. There was no apparent correlation between the days without bowel movement and dates on which the laxative had been recorded as given on the Medication Administration Record (MAR). One staff member told us, "The GP has said it has to be regular, every morning but some people ask if he wants it". Another said, "He was dehydrated on regular laxative, it is less medication and more diet managed now". We found that staff did not have adequate guidance on how to minimise the risk of constipation for this person and that medication to reduce the risk was not administered using a consistent approach.

The information relating to each person's needs and risks to their health was not always consistent or up to date. Each person had a 'support file' and a 'health file'. For one person we read in the support file that they were registered partially sighted and that they may require chest physio (used to clear mucus) from staff if they became tight chested or wheezy. When we looked at the health file for the same person we read that they had no issues with their chest or breathing and that in answer to the question, 'Is the service user registered partially sighted or blind?', 'No' had been recorded. The manager informed us that staff had not been trained to provide chest physio and that this was not required. This same person had been receiving treatment for a pressure area but this had recently healed. The support plan had not yet been updated to reflect that the pressure area had healed and that district nurses were no longer visiting to dress the wound. We found that people were at risk of receiving inconsistent or unsafe care because records of risks to the health and safety of each person and details on how to mitigate them contained inconsistencies.

The provider had not done all that was reasonably practicable to mitigate risks to people's safety because care records lacked detail and monitoring was not always effective. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our visit, the manager sent us a copy of guidance related to laxatives that had been updated for two people who used the service. This included information on how to use the bowel monitoring chart to determine if a dose of laxative was required and on how many days to wait before contacting the GP if the treatment was not effective.

Risks to people's safety had been assessed. Where risks had been identified, such as in moving and handling or where people experienced seizures, these had been assessed. For each risk identified, guidelines were in place to describe how to minimise the risk and the support that people required from staff. For example, there was information on how many staff were required to support each person with transfers, information on the mobility aids they used and on how often these required servicing to ensure that they were safe to

use. Risk assessments were also in place for accessing the community, crossing the road and cooking sessions. Staff demonstrated a good understanding of people's support needs and on how to keep them safe. We observed staff prompted people to take care, for example when going through a door way so that they did not bang their elbows on the door frame. The provider had also taken action to minimise the risk of injury from angular edges by fitting semi-circular shaped protectors to the lower part of each door frame.

There were enough staff on duty to keep people safe. People told us they enjoyed a variety of activities and were able to go out in the community. The planned staffing levels for the home were three staff in the morning and afternoon, with one and a half at night (a second member of staff worked between this service and the adjacent service run by the provider during the night shift). The manager explained that the home had been fully staffed up until one month before our visit. As a result of the vacancies we noted that some shifts had been staffed with two rather than three staff and that on occasion, there was just one member of night staff. The manager explained that the service would never be unattended, and that if two staff were needed for any transfers during the night shift, staff from a third service run by the provider, located within walking distance, would be called upon. Staff felt confident that there were enough staff on duty to meet people's needs. One said, "We can manage on two but when we are three it is better". During the morning of our visit one staff member had called in sick so there were two staff on duty. We observed that people received prompt attention and were supported to participate in tasks such as preparing their breakfast and cleaning their bedrooms.

The manager was recruiting to fill the vacancies and offers had been made to new staff to start work. We heard the manager chasing up references for one newly appointed staff member who was waiting to start. Staff files demonstrated that pre-employment checks had been completed before new members of staff were allowed to start work. This included checks on their previous employment history and with the Disclosure and Barring Service (DBS). The DBS provides criminal records checks and helps employers make safer recruitment decisions. In addition, two references were obtained from current and past employers. These measures helped to ensure that new staff were safe to work with adults at risk.

People told us that they got on well with staff and with each other and that they felt safe at the service. Posters entitled, 'What is abuse and how can I report it' were displayed in people's bedrooms and were in an easy-to-read, pictorial format. Staff had attended training in safeguarding adults at risk. They were able to speak about the different types of abuse and described the action they would take to protect people if they suspected they had been harmed or were at risk of harm.

The home had a safeguarding 'grab folder' which included the provider's safeguarding and whistleblowing policies along with a flow chart explaining how to report an incident or allegation of abuse. Staff told us they felt able to approach the manager if they had concerns. They also knew where to access up-to-date contact information for the local authority safeguarding team.

People received their medicines safely. The competency of staff who administered medicines had been checked. Staff completed the Medication Administration Record (MAR) after each administration which demonstrated that medicines had been given as prescribed. Where medicines were prescribed on a variable dose, such as for pain relief, the time of administration and dose given was clearly recorded. This helped to ensure that doses were spaced appropriately and that the maximum daily dose was not exceeded. There was information on how each person liked to take their medicines and at what time. We noted that one person took their morning medicines mid-morning rather than first thing. This had been agreed with the GP and was more effective as the person was more alert at the later time.

Each person had a lockable cabinet in their bedroom which was used to store their personal medicines. On

each cabinet there was guidance for staff on how long medicines should be stored for, such as for liquids or creams once they had been opened. We found, however, that staff had not always recorded the date of opening on the bottles or tubs. This meant that they would not necessarily know when they should be disposed of. If stored for too long, medicines may lose their effectiveness. We noted that in the February medication audit the staff member completing it had found that all medicines included an opening date. Before we left, the deputy manager checked all of the liquid and cream medicines and updated them with an opening date based on the delivery date. This meant that they would be disposed of within the recommended timeframe.

Good

Is the service effective?

Our findings

Staff spoke positively about the training they received and told us they felt confident they had the skills to support people. When we asked one person if staff knew how to support them, they smiled and gave us the thumbs up. One staff member said, "The training is helpful, it has helped me with the work". Another told us, "CMG (the provider) do top training, quite robust and a lot of it is face to face". Courses included communication, emergency first aid at work, food safety, infection prevention and control, the Mental Capacity Act 2005 (MCA) and safeguarding. There were also specific courses on learning disabilities, epilepsy and one entitled, 'person-centred active support'. Staff told us that they were able to request additional training and that they were supported to complete nationally recognised qualifications such as the diplomas in health and social care.

The manager maintained records of staff training and was able to see clearly which training was due to be refreshed and which staff were booked on forthcoming courses. At the time of our visit, the completion rate for staff training was over 80%. For each staff member who was overdue training we saw that a course had been booked or that the manager was waiting for a suitable course to become available locally. The manager had also requested a course on postural management to be delivered at the service so that all staff could attend.

New staff completed a period of induction which included orientation, training and shadowing experienced staff. One staff member who had recently started told us, "I felt comfortable at all times, the training was good". The manager explained that she had attended training in the Care Certificate, which is a nationally recognised qualification, and that this training programme would be used for any new staff who had not previously worked in the sector.

Staff felt supported in their roles and received regular supervision. Records confirmed that staff had attended three supervision meetings and an annual appraisal with their line managers. This provided an opportunity for them to discuss achievements, concerns and professional development. One staff member said, "If you've got any concerns you can mention it". The manager had not yet conducted appraisals with all staff but these meetings were scheduled for June 2016.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our visit, two authorisations to deprive people of their liberty had been granted by

the 'Supervisory Body' and one was pending. The manager had not informed the Commission of the DoLS which had been authorised, which is a legal requirement. Following our visit, the manager confirmed that the missing notifications had been sent.

Staff understood the requirements of the MCA and put this into practice. For example, staff followed the presumption that people had capacity to consent by asking if they wanted assistance and waiting for their response. In one person's support plan we read, 'I need a lot of assistance from the staff team to make choices. I am able to make simple choices like where I would like to go and what I would like to wear'. During our visit we observed that staff involved people in decisions and respected their choices. For each person, staff had competed a checklist of 'potentially restrictive practices', such as the use of a lap belt, having one to one support in the community or the use of bedrails. These practices had been assessed and the person had been involved in the decision making process. One person who used bedrails confirmed to us that they were happy to have them in place.

People told us they enjoyed the food and were involved in planning the menu. There was a weekly menu planning meeting where people were able to make suggestions. Some people also accompanied staff on the weekly supermarket shop and were able to add additional products. Each person's food and drink preferences were recorded in their support plans. In one person's support plan we read, 'I really like cheese sandwiches and crumpets, so if I do not want the bigger meal offer me one of these'. We saw in the minutes of a staff meeting that the manager had encouraged staff to cook from raw ingredients, for example by buying mincemeat to make burgers rather than buying them ready-made. At mealtimes, people were supported to eat and drink if necessary. Some people used non-slip mats, plate guards or adapted cutlery to enable them to eat independently. Staff maintained a food and fluid diary for each person as part of their daily notes. This helped to ensure that they were eating and drinking enough and that they ate a balanced diet.

People had access to healthcare professionals to ensure their health needs were met. Each person had a Health Action Plan (HAP) with details about their health needs and the professionals involved. People had been supported to attend regular dentist and chiropody appointments, as well as medication reviews with their GP. Records of these appointments were not always updated in people's support plans but the manager maintained a list, which showed last and next appointment for each person. The manager said, "They are good at booking (appointments) but not very good at recording, but they are getting better. There is much more in the files than when I started".

The service was a bungalow located in a residential street. There was a sloped path to the front door and a ramp up to the patio doors at the rear. One person told us they had selected colours for their bedroom to be redecorated. The manager explained to us that some of the lighting had been changed, for example replacing strip lights with more homely bulbs and lightshades. Funding had been agreed to replace the kitchen and the manager was looking at options, which included the possibility of a lower level cooker to enable people using wheelchairs to participate more actively in meal preparation.

Good

Is the service caring?

Our findings

Throughout our visit, there was a happy and friendly atmosphere at the service. People were relaxed in the company of staff and it was apparent that staff knew people well. One person told us, "They're good" when we asked about the staff. Staff supported people to maintain relationships with family and friends that were important to them. In one person's support plan we saw a list of birthdays. This person told us that staff helped them to send greetings cards.

Each person had a keyworker who took a lead in planning their support. One staff member described this role as, 'I'm responsible to make sure he's got what he needs. Recently we have discussed where he wants to go on holiday and new activities'. People we spoke with were able to tell us who their keyworker was. Each month people had a one to one meeting with their keyworker where they could discuss their support, any future plans and share any concerns. People told us these meetings were useful.

People had been involved in planning their care. One person was susceptible to developing pressure areas and needed to have two hours of rest in bed each day. When we spoke with this person it was clear that they understood the need for this. This same person had worked closely with staff to make changes to their diet and lifestyle. Staff described how the person had enjoyed searching for new recipes online and participated actively in menu planning. They had also continued to attend the gym on a weekly basis. These lifestyle changes had made a significant difference to the person's health and wellbeing.

Each person's support plan included details of the tasks they were able to complete independently. For example, 'I am able to brush my own teeth, you are to put the toothpaste on the brush then hand it to me' and, 'I am able to push myself back using my arm rests once I am in my chair'. There was also detail on the tasks people enjoyed helping with around the house such as stacking the dishwasher or managing the recycling. We observed that staff encouraged people to be as independent as they were able, for example by asking them to turn the kettle on when making a coffee or supporting them to turn the phone off after making a call. One person was very proud to show us their new wardrobe, which included sliding doors and a full length mirror. Staff explained to us that this person took an interest in their appearance but had not been able to independently access clothes from their previous wardrobe. They were now able to position their wheelchair alongside the clothes and take them from the rail independently; they were also able to see their full body in the mirror.

Staff treated people respectfully. When we were reviewing medicines the staff member ensured that each person was happy for us to enter their bedrooms and look in the cabinets. We observed that the staff member rephrased the question or invited the person to accompany us to make sure that they were in agreement. People were able to take phone calls in the privacy of their bedrooms and were encouraged to be actively involved in how and where they wished to spend their time. We found that staff demonstrated the provider's value of dignity and respect which was described as ensuring that, 'Every service user and their families are supported with dignity, respect and as an individual'.

Good

Is the service responsive?

Our findings

Staff knew people well and understood how they liked to be supported. Each person's support plan included details on how staff should assist them with daily tasks such as personal care, mobility and mealtimes. The support plans were personalised to the individual and included information on their interests and preferences, such as for male or female staff to assist them. We read that one person enjoyed five to ten minutes in the shower at the end of personal care to relax with the water. For another person there was a list of, 'Things I like to talk about' to help staff to engage with them. Staff felt that the care plans were useful and that they gave a good insight into each person.

Although we noted some inconsistencies in the care records, as noted in the 'Safe' section of this report, we found that staff had taken action to respond quickly to any changes in people's needs or behaviour. The manager had made a referral to the provider's behaviour support team for one person who had started to shout at staff and regularly refuse their medicines. Staff had also noticed that this person was less communicative than usual. At the time of our visit, staff were keeping detailed records of this person's emotions and anxiety levels throughout the day. This would be reviewed by the specialist team to try and identify any triggers for the behaviour and to assist staff to provide appropriate support.

Each person's communication preferences were detailed in their care plans. For example, we read, 'If I am happy with the choice I will smile and laugh, wave my arms about and say thank you. I like to giggle and will clap my hands when I am excited about activities. If I am unhappy with the choice I will go very quiet and not respond to you'. For those people who were unable to use verbal communication, the support plans also included guidance on how they presented if they were distressed or anxious. Staff were knowledgeable about people's varied communication styles and were able to guide us. At the time of our visit, information on how people communicated was not readily available to visitors, for example by attaching a communication passport to the person's wheelchair. This had been picked up by a representative of the provider in a recent audit and was being addressed by the manager.

People's care and support was reviewed monthly by their keyworker. This included details of progress, challenges and changes in their support needs. Staff shared with us examples of how they had supported people to achieve individual goals, such as to complete a college course or to arrange adventurous holidays.

People were involved in a variety of activities that interested them. On the day of our visit, everyone attended the 'Tuesday Club', a social event which involved people from a number of services run by the provider. One person went out for a walk in the local area with a staff member and another was at a day centre during the morning. People told us they went to the pub, gym, shopping and to a weekly disco. Each person had an activity planner for the week and was able to make suggestions for new activities to their keyworker. The service shared a minibus with another service run by the provider and had arranged trips out to local places of interest. At Easter people had been involved in an Easter party which included an Easter bonnet competition. One person told us, "It's good. I enjoy everything. Work (day centre) keeps me busy". A staff member said, "I like that we go out a lot; for a drive, bowling or to the cinema".

People felt confident to raise concerns with staff. During our visit, one person mentioned they were waiting for a new shower chair. Staff were able to update this person, advising that it had been ordered but a delivery date had not yet been confirmed. People were asked during their monthly keyworker meetings and as a group at house meetings if there were any points that they wished to discuss. At the time of our visit people had not been asked for feedback on the service in the form of a survey.

The provider had a complaints policy and information on how to complain was available in written and an easy to read format. This explained the timescales within which people could expect a response. There was also information on who to contact if the complaint had not been resolved to the complainant's satisfaction. The manager maintained a log to record compliments and complaints received. Since she started in post in October 2015, no complaints had been received.

Good

Is the service well-led?

Our findings

There was a friendly and upbeat atmosphere at the service. The manager and staff team were open and approachable. They spoke with enthusiasm about the service and their vision for improvements they wished to make to further enhance the opportunities and care for people. The manager told us, "I'm very proud of my team, they deal with problems themselves now they have the confidence. It's a happy team here". One staff member said, "It's a lovely atmosphere, it isn't even like coming to work".

The service was in a period of transition, with the new manager having started in post at the end of October 2015. The manager was responsible for this service and for an adjacent service, also run by the provider. She had recently submitted her application to register with the Commission and was working towards her level five diploma in health and social care. Prior to October, the service had been without consistent management for several months, which had an impact on the running of the service. The manager told us, "All those changes didn't have a very good impact on them (people using the service). With the very big rotation of staff the guys didn't feel very stable".

People and staff spoke positively about the manager. One person said that she was, "Nice" and said, "I can talk to her". A staff member told us, "(The manager) is very approachable. It's very easy to ask questions". A representative of the provider who had taken over responsibility for the service shortly before the manager was appointed said, "The change in the service since (name of manager) came in is phenomenal". It was clear from our conversations with people and staff that they had confidence in the leadership of the service. They spoke of the stability and the fact that new systems had been put in place to help them in their work. Staff told us how progress had been made in ordering new equipment such as hoist slings.

The manager split her time between the two services that she was responsible for. This meant that she spent either two or three days per week at this service. In addition, she had worked on weekend and night shifts. She told us that this was important for her to understand the challenges and to see where improvements could be made for people or staff.

The manager and provider used a series of audits to monitor the quality of the service. This included daily, weekly and monthly checks as well as formal audits of the service. The November 2015 audit of the service by a representative of the provider had resulted in a lengthy action plan. The manager shared a copy with us and it was clear that significant progress had been made in addressing the actions listed. Many actions were completed, for example a new system was in place for recording the stock of boxed medication. Others were planned for future dates, including a fire evacuation under night-time conditions which had been scheduled for the warmer summer months. A further audit by a representative of the provider in March 2016, using a new format, had scored the service at 87.6%. This audit covered support plans, staff files, staff training and health and safety of the premises. We found that the audits were used effectively to identify areas for improvement and to track progress.

People were involved in some of the checks at the service. One person helped with monthly safety checks and daily fire checks. On the day of our visit we saw this person checking the fire extinguisher service dates

with a staff member. The manager completed a monthly audit of medication. Other checks were delegated to lead support workers, such as checking the contents of the first aid kit and cleaning schedules. Some checks were carried out by external companies, for example safety checks on hoisting equipment and a mediation audit by the pharmacy. Any actions from these visits had been clearly recorded to ensure that they were not missed. Points for immediate attention were recorded in the staff communication book.

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 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way because information on the risks to people's health and safety and on how to mitigate them was not always consistent or sufficient. Regulation 12 (1) (2)(b)