

Creative Support Limited

Doseley Road

Inspection report

199 Doseley Road
Dawley
Telford
Shropshire
TF4 3AZ

Tel: 01952506105

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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?

Requires Improvement ●

Summary of findings

Overall summary

About the service: Doseley Road is a registered care home for adults with learning disabilities. At the time of inspection there were three people living in the home.

People's experience of using this service:

People did not receive care and support that was delivered in line with the Mental Capacity Act. There was no evidence that people's capacity had been assessed and best interest meetings had been held.

Governance systems were not effective at identifying and acting upon necessary improvements.

Risk assessments were not always completed to the standard required and key information was found to be lacking.

The property had not been maintained to a standard that prevented impact on the people living there. Infection control risks were increased due to work not being undertaken.

People received their medicine on time by trained staff however, missed signatures on the medicine administration records had not been highlighted

There was not a registered manager in post at the time of inspection.

Accident and incidents forms were reviewed by the provider.

People were supported by a team that worked together although concerns were raised about the volume of agency staff that had been used.

People were supported by staff who had been safely recruited.

Staff members sought advice from other professionals when necessary.

People had access to activities although there had been a reduction in the range and frequency of activities due to staff issues.

People were supported to access healthcare.

People were treated with kindness and respect and involved in day to day decisions. Although this was impacted by agency usage if the agency worker did not know the people.

People were supported to have a balanced diet.

People were supported by a staff team that had received training relevant to their role.

People were safeguarded from the risk of abuse

People had access to a complaints process but relied on others to raise concerns on their behalf.

People's end of life wishes had been considered.

The provider worked alongside people's families and the local authority.

More information is in the full report

Rating at last inspection: This was the first inspection of this home under its current provider therefore there was no previous rating.

Why we inspected: This was a planned comprehensive inspection, however we had received some concerns regarding the staffing levels in the home.

Enforcement: Please see the action we have told the provider to at the end of the end of the report.

Follow up: We will continue to monitor the home and the required improvements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our Safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our Effective findings below.

Requires Improvement ●

Is the service caring?

The service was not always caring.

Details are in our Caring findings below.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Details are in our Responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well led.

Details are in our Well-led findings below.

Requires Improvement ●

Doseley Road

Detailed findings

Background to this inspection

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

Inspection team: The inspection team consisted of one Inspector

Service and service type: Doseley Road is a registered care home service without nursing. The home provides support to adults with learning disabilities and/or autistic spectrum disorder.

On the day of inspection there was no registered manager in place. A registered manager is someone who alongside the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: The inspection was unannounced.

What we did: Prior to the inspection we reviewed intelligence we held on the service. This included the 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. As well as notifications we had received in relation to any serious incidents or safeguarding reports. We also spoke with a representative from the Local Authority.

As part of the inspection we reviewed the care plans for all three people living in the home. Due to the limited verbal communication skills of the people living in the home we spent time observing the interactions between people and the staff team. We looked at three staff files and records held in the service. These included the staff rota, health and safety checks, audits and action plans and minutes of meetings. On the day of inspection, the home was audited by their pharmacy provider and we reviewed the findings of their audit. We interviewed three members of staff, the deputy manager and another manager for the provider who has applied to CQC to take over the registered managers role. As part of reviewing the fire safety in the home we discussed our findings with the Fire Brigade.

Following the inspection we spoke with four family members.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. Some aspects of the service were not always safe. There was an increased risk that people could be harmed.

Preventing and controlling infection

- The kitchen in the home had been highlighted for refurbishment but this had not been completed at the time of inspection. The provider informed us that because this work was not done they had received a poor rating from the Environmental Health Department and were now in the process of getting the work completed.
- We checked the risk assessments for cleaning products and found that the provider had not completed the individual product assessments, required under the Control of Substances Hazardous to Health (COSHH) regulations. This meant the risks to anyone using the products had not been considered.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

- The home was clean and records indicated regular cleaning tasks were undertaken.

Assessing risk, safety monitoring and management;

- Risks to people's safety were not always assessed by the provider. We found one person had a stair gate in place at night due to a risk of them falling down the stairs. However, the person's falls risk assessment did not mention the risk of falling down the stairs or that a stair gate was required to mitigate the risk. Further to this the use of a stair gate was not mentioned in the home's fire risk assessment or the individual's Personal Emergency Evacuation Plan (PEEP).
- Due to our concerns that key information was missing from the fire documentation we contacted the Fire Brigade for clarification on the details required. The Fire Brigade confirmed that the stair gate should be referenced in both the fire risk assessment and the person's PEEP. We saw documentation from the Fire Brigade following their last visit to the service, stating the home was broadly compliant with the fire regulations but had recommended further details were included. These recommendations had not been acted upon despite reviews of the fire risk assessment taking place. We discussed the concern with the provider who has now scheduled for the fire risk assessment to be reviewed by the provider's health and safety officer to ensure the information is robust.

Staffing and recruitment

- People were supported by sufficient numbers of staff. However there have been a number of concerns raised around the volume of agency staff that had been used in the past year. On the day of inspection there were two agency staff working alongside the provider's own staff members. We saw that the agency workers on shift did know people. We were told this was due to them having worked in the home on a regular basis. One relative said, "The use of agency staff has had a huge impact on people's care as agency staff do not initially know how people communicate, the activities people enjoyed have stopped and it is unsettling for everyone seeing lots of new faces."
- We could see from the rota that there had been high usage of agency staff but that this was reducing as new

staff were coming in to the service.

- People were supported by staff who were recruited using safe recruitment procedures.

Using medicines safely

- People received their medicine by staff who were trained to administer.
- On the day of inspection, the home was audited by their pharmacy provider. We spoke with the pharmacy provider following their audit and reviewed the report the provider received. The report stated the processes in place were safe and that the home had the correct guidance for staff to follow.
- The pharmacy audit did identify that there were some missing signatures on the current Medication Administration Record (MAR) but that the medicine had been given. The system the home had in place had failed to lead to a report being made that signatures were missing.

Systems and processes to safeguard people from the risk of abuse

- People were protected from harm by a staff team that had been trained to recognise and report abuse. The homes rota ensured there was always a permanent member of staff on shift who had oversight of the people living in the home. One staff member told us, "People are safe here and staff are confident to report concerns"
- Information was displayed on notice boards highlighting reporting procedures should anyone have any concerns.
- The provider had referred incidents to the local authority safeguarding team as required.

Learning lessons when things go wrong

- Accident and incident forms were completed and there was a process in place to demonstrate that these were reviewed on a monthly basis.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes and was not delivered in line with the Mental Capacity Act.

Ensuring consent to care and treatment in line with law and guidance

- 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
- People's care had not been delivered in line with the principles of the MCA. We identified restrictions were being imposed on people but could not find the necessary audit trail to support such restrictions or evidence these were the least restrictive.
- DoLS applications had been submitted to the Local Authority on people's behalf but no assessment of capacity had been completed or best interests meeting held.
- We found that the provider had asked families to provide consent on documentation when there was no legal authority in place to do so. As well as recording that people had given their authorisation for the staff to manage their medicine and finances, when they lacked the capacity to make that decision.
- We noted that some of the restrictions in place had been long standing and put in place by the previous provider. The current provider could not evidence that they had reviewed inherited practices and reassured themselves that the legislation had been met.
- We spoke to the provider and asked them to review their application of the MCA and all restrictions in place. We shared our concerns with the Local Authority.

These issues are a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People had person centred information in their care files. Information included the person's history, likes and dislikes and daily living skills. Routines that were important to people were clear and how to support people with any behaviour that challenged.
- People had lived at the service for many years and their family members all stated to us that the home was

suitable for people's needs but there were concerns that needed to be addressed. One family member told us, "Everything used to be in place that was needed but we have had a few worries which we have told the managers about."

Staff support: induction, training, skills and experience

- Staff completed training relevant to their role. One staff member told us, "The training has picked up of late but it possibly still not to the level required."
- We were made aware that staff had completed some in house behaviour training but this was not included on the matrix so we were unclear how many staff had attended or the depth of training received. We also did not see any record on the matrix of courses specific to adults with learning disabilities and /or people with communication needs.
- Staff told us they had occasional supervision meetings with a line manager but appraisals remain outstanding.

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported to eat a balanced diet and access to drinks and snacks when they wanted. We identified that access to the fridge was restricted but we did observe staff opening it for people on a regular basis.

Staff working with other agencies to provide consistent, effective, timely care

- On the day of inspection, we observed a staff member liaising with the GP regarding a change in a person's presentation. They provided clear and concise information and a home visit was arranged for the coming week. We also observed the same staff member speaking with a person's day centre and communicating the plan for the day. They shared relevant information to ensure the day centre were aware of how the person had been, so that they could adjust their care accordingly.
- We saw documentation in the care files from a range of professionals who had supported people and provided professional advice. This information was made accessible for staff to see.

Adapting service, design, decoration to meet people's needs

- People lived in an ordinary house on a residential road. Bathroom areas had been adapted to meet people's needs and space identified in the house for people to engage in activities or have quiet time. The provider had decorated key areas of the home but failed to refurbish the kitchen area.
- Staff told us that they would like to improve the design of the building and garden area to include more sensory stimulation for people. One staff member told us, "We need more sensory stimulation and want to do up the garden and the upstairs space."

Supporting people to live healthier lives, access healthcare services and support

- People had access to health care and on the day of inspection we observed a staff member speaking with the GP around a change in a person's presentation which worried them. One family member said, "A lot of the activities people used to do to stay healthy have stopped such as, horse-riding or regular swimming sessions. It would be good if they could be restarted."

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were not always well-supported.

Ensuring people are well treated and supported; equality and diversity

- People were treated with kindness and supported throughout the day. Staff on duty knew people well and interacted with them in a positive way. Unfortunately, we received consistent feedback that the staffing issues had impacted on people and that the high use of agency meant that people's needs were not always understood by everyone on shift. When we looked at the rota we could see that the agency use was reducing but there were still hours which the provider could not cover. This meant the issues created by having unfamiliar staff in the home were not going to be immediately resolved.
- One family member told us, "We asked the previous manager to make sure that they get the mix of staff right as (relative name) does not respond to everyone, even when the staff members are good. If they don't have the right mix, people don't have anyone to go to and maybe more difficult to support."
- People were supported to celebrate traditional festivals throughout the year. People's protected characteristics were considered as required by the Equalities Act 2010.

Supporting people to express their views and be involved in making decisions about their care

- People were spoken to throughout the day and their opinion was asked. When necessary objects were used to support understanding. For example, food options were made clear by visually looking at food items. One staff member said, "We would like to do more in the home to improve our communication with people by possibly having training or more communication aids to use."
- Staff consulted with people's families when they were unsure. We observed one person's sleep routine had been disturbed and the staff were unsure if to take the person to day services or not. The staff member spoke with the person's family and discussed the best option.

Respecting and promoting people's privacy, dignity and independence

- People were prevented from maintaining their routines and a level of independence due to the downstairs bathroom being out of order. The provider had requested a repair but had not been able to get the work completed. Two family members mentioned the impact this had on their relative. One family member told us, "The repair has been taking ages and it is confusing for people to have to go upstairs, (relative name) now thinks it is bedtime when they go to the toilet in the evening."
- People were treated with dignity and respect by the staff supporting them. Staff took time to explain what was happening during the day and included people in conversations. We observed at meal times people were encouraged by staff to do tasks for themselves where possible.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- People had individual activity time tables contained in their files. There were some gaps in the records but most of the planned activities we saw had taken place.
- The provider told us that there had been a problem with a lack of drivers and that this had impacted on people getting out to do things they enjoy but that things were getting better.
- On the day of inspection, we saw a rota for drivers and each person left the house at some point during the day. However, when we spoke with the families they all stated there had been a reduction in the type of activities people were offered. For example, one family member said, "I know they have had some staffing issues and the staff there try their best but I would like more activities as I don't want (relative name) stuck in doors more than necessary."
- People did have access to in-house activities and the staff told us they are always looking at new things people may enjoy. One staff member said, "I've recently purchased some new games and activities and we do them together. It can be hard as people have a low concentration span but we keep trying new things."

Improving care quality in response to complaints or concerns

- People living in the home relied on family members and staff to raise concerns on their behalf. We were made aware that the local authority recently met with the provider and family members to discuss the families concerns about the quality of the service being provided. Concerns included the need for permanent staff, people's activities, communication and management oversight. All families spoken with told us they want the provider to improve so that people could return to the level of care previously experienced and remain living at Doseley Road.
- We saw the provider's complaints procedure displayed in the home and that systems were in place to record and review any formal complaints received.
- We saw that an anonymous complaint to CQC in 2018 had been investigated and an action plan was created.

End of life care and support

- There was no one in receipt of end of life care. We saw that people had their end of life wishes considered, with the input of family members.

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Governance systems were not effective and management was inconsistent

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- People were not protected by effective governance systems. We found that the systems in place had failed to identify areas of improvement and concerns previously identified had not been acted upon.
- People's care had not been managed in line with the MCA (2005) and the provider had failed to identify this as part of their audit process. People were not having their capacity assessed and best interest meetings could not be evidenced. People had restrictions in place that the provider could not demonstrate were required and the least restrictive.
- Risks to people's safety had not been assessed and measures inherited from the previous provider had been adopted without considering if they were still appropriate. The fire risk assessment was not reflective of the current situation despite being recently reviewed by the provider. COSHH risk assessments for individual products had not been completed despite an action plan stating this work had been completed.
- Systems were in place to check for errors but they were not always effective. A recent pharmacy audit highlighted that balance checks for medicines were completed and people had received their medicine. However, missing signatures on the Medication Administration Record were found that had not been brought to anyone's attention despite the provider's system being in place.
- We found that the property had not been maintained to a level that avoided impact on the people living in the home. The kitchen had been reported as needing refurbishment for some time but this work had not been completed, this had led to a poor rating from the Environmental Health Department. The downstairs toilet was out of order and the delayed repair had impacted on people's independence and daily routine.

These issues are a breach of Regulation 17 of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014

- The home did not have a manager registered with the care quality commission. Following the inspection, we saw that a manager already working for the provider had submitted an application to take on the role. One staff member told us, "Changes in the management have been tough on the team but we do our best. We all would just like some stability."

Continuous learning and improving care

- People were not supported by quality assurance systems that were applied on a consistent basis and improvements were not always identified. We saw that audits were in place and completed but the outcomes did not facilitate all the improvements required. One staff member told us, "The staff always try to

share ideas with each other and we try to resolve any issues that we can, but some things are out of our hands."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People were supported to be engaged with the community and had a community presence in the local area.
- Staff attended regular team meetings and worked well together. The staff spoken with were positive about their role and enjoyed the work they did. One staff member said, "I love coming to work, sometimes it can be a challenge but we have really positive days." Another staff member told us, "I enjoy coming to work and I am enthusiastic about people and if they are upset, I will do everything to find out what is wrong."

Working in partnership with others

- The provider worked closely with the families of people living in the home and considered their opinion when making decisions. Regular meetings were held with the local authority to review the contract and people were supported to access various health care professionals.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Refurbishment of the kitchen in the property had not been completed which resulted in a poor rating being received from the Environmental Health Department.</p> <p>COSHH risk assessments had not been completed.</p>

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>The principals of the Mental Capacity Act were not met. People's capacity had not been assessed and there was no evidence that best interest meetings had been held. We could not find evidence to demonstrate that the restrictions in place were considered to be the least restrictive</p>

The enforcement action we took:

We issued a Warning notice to the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>People were not protected by adequate governance systems. The providers current systems has not identified the concerns we found in relation to people's safety and the lack of adherence to the Mental Capacity Act.</p>

The enforcement action we took:

We issued a warning notice to the provider