Consensus Support Services Limited

Consensus Support Services Limited - 121 Station Road

Inspection report

121 Station Road
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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Overall summary

This inspection took place on 7 January 2015 and was unannounced. Consensus Support Services Limited – 121 Station Road provides residential and nursing care for up to 11 people with learning and physical disabilities and autistic spectrum disorder.

At the last inspection in August 2014 the provider was not meeting all the legal requirements. We asked the provider to take action to make improvements to the service and the provider had taken appropriate action to meet the relevant requirements.

At the time of this inspection there was no registered manager in post. A registered manager is a person who

Summary of findings

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. However a new manager had recently been appointed and plans had been put in place for them to register as the manager with the Care Quality Commission.

Suitable arrangements were in place to prevent abuse happening and the staff having a good understanding of safeguarding issues were knowledgeable of the local safeguarding reporting procedures.

The provider had increased the staffing levels. Robust staff recruitment systems were practiced and staff were provided with the necessary training to ensure they had the skills and knowledge to meet the specific needs of people living at the home.

Systems were in place for receiving, administering and disposing of medicines. But further improvement was needed in this area.

The staff interacted with people living at the home in a caring, respectful and professional manner. They knew and understood people's individual care and support needs and people's care was provided in ways that respected privacy and dignity.

The interim manager had knowledge of the mental health act (MCA) 2005 and the deprivation of liberty safeguards (DoLS) legislation.

People received a varied, healthy and nutritious diet and people at risk of not receiving adequate nutrition had their food and drinks closely monitored.

People's healthcare needs were regularly monitored and assistance was sought from the relevant professionals so that they were supported to maintain good health and wellbeing.

The interim manager had implemented positive changes to the service and people were encouraged to speak up if they were unhappy with the service provided. Systems were in place to obtain feedback from people living at the home and their relatives, in the form of satisfaction surveys. However further improvement was needed to fully address the outcomes of the last satisfaction survey.

Suitable management arrangements were in place to oversee the quality of care provided and to monitor risks.

Summary of findings

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 always safe.

The staff knew how to identify abuse and what action to take to keep people safe.

Medicines were administered safely. However the systems to manage the storage and administration of medicines were not sufficiently robust to ensure medicines were always safely administered.

There was sufficient staff on duty to keep people safe and to provide care and support to people when they needed it.

Effective recruitment practices were followed.

Is the service effective?

Good

The service was effective.

People's consent to care and support had been obtained in accordance with the Mental Capacity Act 2005.

People's health and nutritional needs were met effectively.

People were looked after by staff who had the knowledge and skills necessary to provide safe and effective care and support.

Is the service caring?

Good

The service was caring.

The staff were knowledgeable about people's support needs and individual preferences.

People told us they were happy living at the home and that staff treated them with kindness, dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were assessed and regularly reviewed. However reviews were not always dated and signed by the reviewer.

People assessed at high risk of pressure area damage did not always have a pressure area care plan in place to specify the pressure area care and support provided to the person.

People's care was individualised and their preferences were catered for as far as was practicable.

People or their representatives had been fully involved in decisions about how their care was planned and delivered.

Summary of findings

Appropriate action was taken to resolve people's complaints.

Is the service well-led?

Good

The service was well-led.

A registered manager was not in post; however plans had been put in place for the newly appointed manager to register with the Care Quality Commission.

Staff had the managerial support they needed to do their job.

Systems were in place to audit the quality of care provided and to monitor risks.

Feedback on the service was sought from people and their representatives. However action plans were not put in place to demonstrate how the feedback was to be used to continually improve the service provided.

Consensus Support Services Limited - 121 Station Road

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 7 January 2015 and was carried out by one inspector and specialist advisor who specialised in the care of people living with physical and learning disabilities.

Before the inspection we contacted commissioners for the service to obtain their feedback on the service. We also reviewed the data we held about the service, including statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law.

During this inspection, we spoke with six people who used the service and one visitor. We also spoke with the management team and five staff that included care and nursing staff.

We reviewed the care records for four people living at the home, which included looking at people's individual care plans and care assessments. We also reviewed records in relation to staff support, training and management records such as quality monitoring audit information.

Requires Improvement

Is the service safe?

Our findings

At our inspection in August 2014 we were concerned about staff recruitment practices and staffing arrangements at the home. At this inspection we found the provider had improved the staff recruitment practices and staffing arrangements.

People living at the home were protected from abuse by staff who supported them to raise any concerns about their safety. One person said, "I like it here and I feel very safe, I would definitely say if I ever felt I was in any harm or danger."

The staff were knowledgeable about the type of incidents that could constitute as abuse and of the company and local safeguarding reporting procedures. The procedures also included how staff could raise safeguarding concerns outside of the home, known as 'whistleblowing'. This involves staff alerting outside agencies, such as the local authority safeguarding agency and / or The Care Quality Commission (CQC). Had they any reason to believe the provider did not take appropriate action to safeguard all people living at the home.

Staff appropriately managed behaviours that challenged the service and supported people from placing themselves or other to harm through using effective communication techniques. People's individual risks were assessed and regularly reviewed.

The provider told us they had recently employed a number of nursing and care staff to increase the staffing levels at the home, as previously there had been a heavy reliance on using staff from care agencies. One person said, "[staff name] is my keyworker and [staff name] is my named nurse and [staff name] works nights. I like having the same staff it makes me feel safe." The staff also confirmed that the staffing levels had increased. One member of staff said, "It's so much better for people living at the home as they get to know the staff who provide their care and support." On the day of our inspection there were sufficient numbers of suitable staff to meet people's needs and keep them safe. People told us they were able to go out and enjoy their hobbies and interests, such as shopping, ice skating, bowling and to the cinema. A relative told us in their opinion their family member did get to go out, but not as often as they would like. With the increased staffing levels it was anticipated this would improve.

Safe and effective recruitment practices were followed to ensure staff were of good character, physically and mentally fit for the role and able to meet people's needs. New staff did not start work until satisfactory employment checks were completed. The provider had carefully selected the staff they employed to ensure they had the necessary skills abilities and experience to provide people with the right care and support. The newly recruited staff that had taken up post commented that they felt much supported by the established staff that worked at the home.

People were supported to take their medicines by staff trained to administer medicines safely. Systems were in place for staff to check that the medicines administration records (MAR) charts, had been signed by staff at the beginning of each staff handover. However we noted that staff had not always signed the MAR record and that the homes own medication audits had also identified several occasions of missing staff signatures. We also noted handwritten entries on the MAR charts were difficult to read. This meant the instructions on the dose and frequencies of the medicines administration were not fully legible for staff to follow. We brought our findings to the attention of the interim manager for their immediate attention.

Arrangements were in place for storing medicines at the correct temperatures. However we noted that staff did not consistently record the medicines fridge temperature or the temperature of the room used for storing percutaneous endoscopic gastrostomy (PEG) artificial feeding preparations. The temperatures on the day of our visit were suitable for storing the medicines. However as staff had not always recorded the temperatures, there was a risk that medicines could have been stored at higher temperatures than the pharmaceutical recommended storage instructions. The provider said they would address the issue to ensure that staff checked and recorded the temperature of the medicines storage areas daily.

The fire risk assessments had been recently reviewed. The staff were familiar with people's individual requirements so that they could be evacuated calmly in the event of an emergency situation. However not all individual emergency plans had been completed for all people living at the home. The interim manager confirmed at the time of the inspection that they were in the process of formalising all of the evacuation plans.

Requires Improvement

Is the service safe?

Procedures were in place for regular maintenance checks of equipment such as lifting and fire fighting equipment to ensure it was in full working order.

Good

Is the service effective?

Our findings

At our inspection in August 2014 we were concerned about the arrangements for staff training and support. At this inspection we found the provider had improved the staff training and support systems.

Staff had completed the provider's induction training programme upon taking up post. They told us when they first started at the home they worked alongside an experienced member of staff. This was also confirmed on the day of our visit on speaking with new members of staff that were working through their induction training.

Staff had completed the necessary health and safety training. They also confirmed they had completed 'specific' training to meet the needs of people using the service. For example, techniques such as, chest physical therapy (CPT), also known as percussion which is an airway clearance technique involving clapping the chest and/or back to help loosen thick secretions making mucous easier to expel or cough up. Staff had also received training on abdominal massage techniques to help relieve constipation, reduce discomfort and pain and promote a feeling of relaxation to improve quality of life. One member of staff said they found learning the techniques very beneficial to the people using the service and that they had helped develop their skills and confidence in meeting people's needs.

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and is required to report on what we find. The MCA sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected. The DoLS are a code of practice to ensure that people are looked after in a way that is least restrictive to their freedom. The interim manager knew how to obtain an urgent authority to request a deprivation of Liberty Safeguards (DoLS).

Staff had received training on the MCA and DoLS. They told us they understood their responsibility to respect people's rights to make decisions. We saw that people's mental capacity was assessed, for example, in respect of managing finances, personal care, moving and handling, the use of bed rails and lap straps. The staff were aware of how to support people who lacked capacity by involving the person's representatives, such as family, friends or formal advocates when making 'best interest' decisions. A visitor told us they were very involved in making decisions on behalf of their relative, who lacked capacity to make some decisions.

Appropriate systems were in place to support staffs development. The staff told us they felt supported by the management and met regularly with their supervisors in private to discuss their work and training needs. We saw that dates for staff supervision and appraisal meetings were planned in advance to allow time to prepare for the meetings with items they wanted to discuss with their supervisor.

People's needs had been assessed and the staff provided support to people in a way that demonstrated their in-depth knowledge of their needs. For example, one person did not like people being too close to them, the staff respected this and sensitively directed people so they did not invade the person's space. This was done in such as way so as the person was involved and included with group activities in a way that did not cause distress.

People living at the home used different methods of communication. Some were able to verbally

communicate, whilst others used body language, facial expressions and gestures and assistive technology to communicate with people. It was evident from our observations that staff understood people's different ways of communicating, by touch, being at eye level with people who were seated and altering their tone of their voice for people who were hard of hearing.

Nutritional assessments were in place to identify any risks to people not receiving sufficient food and hydration to maintain a balance diet. The meals were home cooked and used fresh ingredients and food supplements were prescribed for people as required. People were encouraged to eat and independently where possible and assistance to eat and drink was provided by the staff. One person told us the staff had helped them to follow a healthy diet and they had been very supportive in helping them to successfully lost weight and manage their weight. The person said, "I have a portion plate and allow myself two to three treats a week, like chocolate or crisps."

People that had their food and drink given by percutaneous endoscopic gastrostomy (PEG) artificial feeding systems had information within their care plans on how staff administered their nutritional feeds. Some

Good

Is the service effective?

people were able to take small amounts of food and drink and detailed information was available for staff to support people to eat and drink safely. Only staff that had received training on supporting people with swallowing difficulties could give food and drinks to people using PEG feed systems or those on a pureed diet. Appropriate systems were in place for staff to closely monitor people's food and fluid intake.

People had regular health reviews with their GP. One person said, "I go to see my doctor at the surgery, I prefer that." Other health care professionals were involved in people's routine day to day care and in response to changes in health conditions.

Good

Is the service caring?

Our findings

People said they were treated considerately and with kindness by the staff. One person said, “I like it here, the staff are very friendly, we have a laugh together.”

People’s privacy was respected. However a visitor said they found it frustrating when staff did not keep their relative’s bedroom clean and tidy. They gave examples of clothing not always being put away neatly, other people’s clothing being found in the drawers and wardrobe and personal care products being left on show within the bedroom. We discussed the visitors concerns with the interim manager and the area manager during the inspection. They agreed that they would arrange to meet with the visitor to discuss their concerns so they could be fully resolved.

All rooms were single occupancy and people were encouraged to personalise their room with items they valued so they felt ‘at home’, such as photographs and small pieces of furniture. People invited their visitors into their rooms or met with them in the communal lounges. A quiet room was also available for people to use if they wished.

Staff interacted positively with people and their manner of approach was patient. We saw staff had conscientiously attended to people when they needed assistance or were observed to be in discomfort.

The care plans gave sufficient information on people’s like and dislikes hobbies and interests. People said they were involved in setting up and reviews of their care plans. The care plans showed where relatives had been involved in making decisions about their relatives care. For example, one care plan stated “My [relative] supports me in all my decision making.” We saw that staff regularly contacting the relative to keep them updated about their health and welfare and any changing needs. This was also confirmed by a visitor who said they were very involved in making decisions on behalf of their relative.

People’s diversity was respected. The staff understood each person’s right to make choices and preferences had to be respected when caring for them. For example, people choosing the gender of staff they wished to provide them their personal care.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed before admission to the home and a care plan was put in place on admission based on the assessment information.

People's care plans were reviewed regularly so that they continued to receive the care they needed. However the care plans were in a typed format and staff had handwritten information onto the plans when people's needs had changed, but the amendments were not always been signed and dated by staff that had made the entries. This made it unsure as to whether the information was current.

Care and treatment was planned and delivered in line with people's individual needs and preferences. Each care plan had a list for staff to sign to say they had read the plan but not all staff had signed to say they had read the care plans. The interim manager said the staff lists needed updating as some of the staff were no longer working at the home and some new staff had started. They said they would update the staff list and ensure that all staff read the care plans and sign to say they had done so.

A pressure area risk assessment for one person identified them as being at high risk; however no pressure area care plan had been put in place. The staff and the interim manager confirmed the person did not have any pressure area skin damage, but due to the fact they were assessed at high risk of pressure area damage to their skin a care plan for pressure area care would be put in place for the person.

People's personal history and preferences were included in their care plans so that staff had an insight into what was important to the person and to assist staff in helping people to achieve their individual goals and aspirations. People were asked "what went well last month" and goals were set for the following month but there was little sign of more medium or long term goal planning.

The staff had a good knowledge of people's past history, which enabled staff to personalise the care they provided to each individual, particularly for those people who were less able to say how they preferred to receive the care they needed.

Appropriate systems were in place for responding to complaints about the service. We found that people's complaints were investigated and resolved, where possible, to their satisfaction.

Good

Is the service well-led?

Our findings

At our inspection in August 2014 we were concerned that people's needs were regularly reviewed and assessed. At this inspection we found the provider had improved the quality monitoring systems to include regular reviews of people's changing needs.

A new manager had recently been appointed and plans had been put in place for them to register as the care home manager with the Care Quality Commission. They were undertaking their induction training, which was provided by the interim manager from another care home in the company.

A new manager had been appointed and their application to register with the Care Quality Commission was still to be submitted. They were undertaking their induction training, which was provided by the interim manager from another care home in the company.

A clinical nurse lead had been appointed and was also new in post. They told us their role was to supervise staff and provide professional development and support to the qualified nursing staff.

People, including staff said the interim manager had made positive changes to the service and they were approachable and encouraged them to speak up if they were unhappy with the service provided. Staff said there had been 'significant' improvements to the service since the interim manager had taken up post. They also said they were pleased that a new permanent manager had recently been appointed. The new manager had been in post for three days and was undergoing their induction training from the interim manager.

Staff said they were particularly pleased that new permanent staff had been employed at the home and that the need to use agency staff had 'vastly reduced'. One member of staff said, "It's really good that we have not used agency staff for at least the last five months, this has been much better for everyone."

Management systems were in place to support staff, comments from the staff were positive about the management of the home. One member of staff said, "The interim manager is very approachable, If I need advice they always help in any way they can."

The interim manager had a clear understanding of their roles and responsibilities with regard to ensuring people received the care they needed. They had taken appropriate action to address areas for improvement identified at the last inspection in August 2014. They demonstrated that they worked positively with the Care Quality Commission and in partnership with service commissioners who have a quality monitoring role when visiting the home.

There were systems in place to audit the quality of care provided and to monitor risks. These included audits of medicines, people's care plans, and risk assessments. Other audits included checking that the equipment used in the home had been maintained according to service schedules, such as hoists, electrical appliances and fire detection systems.

The provider had arrangements in place for a senior staff member of the company to visit the home regularly to meet with the manager and review the progress on implementing previously agreed action plans for improvements.

Senior management were visible throughout the day coming to the home to undertake previously planned activity. The internal auditor arrived at the same time as ourselves but re-arranged their audit to minimise the disruption in the home.

Feedback was obtained from people living at the home and their relatives. Through informal arrangements such as discussions with staff while visiting the home, or by more formal arrangements such as completing annual satisfaction surveys. We looked at the results of the satisfaction survey that was completed in September 2014 at which people said they would like more to do, such as trips to the seaside, play musical instruments, more community trips and make the home nicer with more furniture. Since the survey was carried out there had been changes in the management of the home and the interim manager said as such they had not had the opportunity to fully address the issues raised from the survey, however they would be addressed as a priority.