# Metropolitan Housing Trust Limited

# Burwell

## Inspection report

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## Ratings

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

## Overall summary

Burwell is registered to provided accommodation and personal care for up to eight people. The Cambridgeshire village home is arranged in two bungalows, numbers 16 and 18. At the time of our inspection there were eight people with a learning disability living at the home.

This comprehensive inspection took place on 10 November 2015 and was announced. This is the first inspection of this service since Metropolitan Housing Trust Limited became the registered provider.

A registered manager was not in post at the time of the inspection. The last registered manager applied to voluntarily cancel their registration and we approved their application so that from 9 April 2015 they were no longer the registered manager for the home. 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

# Summary of findings

the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The current manager's application to be registered was in progress.

People were provided with support and care by a sufficient number of staff. Whilst recruitment of permanent staff was taking place there were measures to fill the staff vacancies. This included the use of agency and bank staff.

Staff were trained and knowledgeable in keeping people safe from the risk of harm.

Recruitment procedures ensured that people were looked after by suitable staff.

People were supported to be kept safe and were supported to be allowed to take risks in their everyday activities.

People were supported to take their medicines as prescribed by staff that were trained and assessed to be competent to do so.

Staff morale was improving due to an increased level of managerial support and increased number of opportunities to attend training.

The CQC is required by law to monitor the Mental Capacity Act 2005 (MCA 2005) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find.. The provider was not acting in accordance with the requirements of the MCA including the DoLS.The provider could not demonstrate how they supported people to make decisions about their care and where they were unable to do so, there were no records showing that decisions were being taken in their best interests. This also meant that people were potentially being deprived of their liberty without the protection of the law.

People were often, but not always, treated by kind, respectful and attentive staff. People were involved in the review of their individual care plans.

Support and care was provided based on people's individual needs and they were supported to maintain contact with their relatives and the local community. People's relatives were not actively involved in the care planning process and were not always kept informed. People took part in a range of hobbies and interests. There was a process in place so that people's concerns and complaints were listened to and these were acted upon.

The manager had experience in care and management and they were supported by their manager. Staff morale and leadership of the home had improved since the change of management of the home. Staff and people were able to make suggestions and actions were taken as a result. Quality monitoring procedures were in place and action was taken where improvements were identified.

We found a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

# 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?**
The service was safe.

Action had been taken to improve the numbers of staff to be able to meet people's needs.

Recruitment procedures ensured that people were looked after by suitable staff.

People received their medicines as prescribed and medicines were kept secure.

**Good**

**Is the service effective?**
Staff were not acting in accordance with the Mental Capacity Act 2005 including the Deprivation of Liberty Safeguards. This mean that people's rights were not being promoted.

Staff were trained and supported to provide people with safe and appropriate care.

People's nutritional, hydration and health needs were met.

**Requires improvement**

**Is the service caring?**
The service was not always caring.

People were treated by staff who were often, but not always, kind and attentive.

People maintained contact with their relatives.

People were involved in reviewing their care plans.

**Requires improvement**

**Is the service responsive?**
The service was not always responsive.

People's relatives were not consistently kept involved in their family member's care.

People's individual communication needs were not consistently responded to.

People were supported to take part in hobbies and interests that were important to them.

People and their relatives knew who they could speak with if they had a concern or complaint. A complaints procedure was in place to respond to people's concerns or complaints.

**Requires improvement**

**Is the service well-led?**
The service was well-led.

**Good**

# Summary of findings

The manager was experienced and supported and managed staff to provide people with safe and appropriate care.

People and staff were enabled to make suggestions and comments about the service and actions were taken in response to these.

There were systems in place to continually monitor and improve the standard and quality of care that people received.

# Burwell

**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 was carried out on 10 November 2015. The provider was given 24 hours' notice because the location provides a small service and we needed to be sure that someone would be in. The inspection was carried out by one inspector and an expert-by-experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience had experience in using and interpreting sign language and looking after a person with a learning disability.

Before the inspection, we looked at all of the information that we had about service. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law. Also before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also made contact with local authority contracts monitoring officer, a GP, a social worker, a speech and language therapist assistant and a community learning disability nurse.

During the inspection we spoke with the manager, two team leaders, a senior support worker [senior carer], three members of care staff, two members of agency staff and three relatives. We observed people's care to assist us in our understanding of the quality of care people received as people we spoke with were unable to tell us about their experience of living at Burwell.

We looked at five people's care records and seven people's medicines administration records. We also looked at records in relation to the management of the service and the management of staff.

Good

# Is the service safe?

## Our findings

A relative said that they had concerns about the staffing numbers but considered that their family member's needs were being met. A senior team leader and manager told us that within the last 12 months there had been a turnover of staff due to a number of personal and work related reasons. Agency and bank staff had been used to cover the staff vacancies. Agency and bank staff members told us that they had worked at the home on a number of occasions. A team leader told us that the use of agency staff was decreasing and said, "It feels like it's moved forward due to a more stable team of staff."

Before the inspection we had received concerns from a learning disability nurse, social worker and a person responsible for placements in the home. They told us that there were not enough staff to fully meet people's needs. Both the provider and a community learning disability nurse told us that there were difficulties in the recruitment of staff due to the rural location of the home. This included supporting people to get out and about. However, improvements have been made in relation to staffing numbers with ongoing recruitment of permanent staff. A team leader told us that there was always enough staff to support people when using transport to attend day care services. They said, "We've always been able to attend so that transport arrangements were in place and people have an escort with transport at all times. There's never been missed times due to a lack of staff. In the last six weeks people have been able to attend evening 'discos', swimming on a Monday and shopping in Bury St Edmunds. The staffing has improved and we have consistent bank and agency staff." Another team leader said, "People are now going out a lot more." A GP told us that there was always enough staff available to support a person to attend the GP practice. They also told us that there was always staff available when they visited to see people at the home.

We saw that there were enough staff to support people with their eating, drinking, personal care and going out into the community. Where people were assessed to require continuous support from one member of staff (one-to-one ratio), the person's one-to-one needs were met. Staffing numbers needed were based on people's individual needs. This included, for instance, when people had a change in their health needs.

The provider had submitted notifications which detailed the action the staff had taken in response to events that had posed a risk of harm to people. Staff had taken the appropriate actions and had followed the correct reporting procedures to minimise the risk of recurrence of similar events.

Staff were trained and knowledgeable in recognising signs of harm. They also knew what action they were to take if they suspected or witnessed any incident of harm experienced by people they looked after. A team leader said, "If a person was being financially abused it would be evident in our financial checks. If a person was experiencing physical abuse they may show this by shying away, a behaviour change or bruising." We saw that staff checked people's individual monies to ensure that people were protected from financial harm. Although people were unable to tell us if they felt safe we saw people interacted with staff without reservation.

People's risks were assessed and measures were in place to minimise the risks. This included supporting people with moving and handling equipment to reduce the risk of injury and supporting people when swimming. A team leader said, "We have to have risk assessments in place. Our job is to promote them [people] taking risks as this is part of life. To make sure that they are kept safe within the risks they are taking. Such as swimming or the risk of having a seizure." They told us about the appropriate use of moving and handling equipment that was used for supporting people when going swimming and the appropriate level of staffing numbers to support people with such an activity.

People had personal evacuation plans so that they would be safely supported in the event of an emergency situation, including the outbreak of a fire. At the time of our visit the fire alarms were tested; a team leader advised us that this safety check was carried out every week. In addition, checks had been carried out on moving and handling equipment and these were up-to-date. We saw that the home's mini buses were certified to be safe for people to use.

Staff recruitment procedures were in place to protect people from unsuitable staff. One member of permanent staff said, "I had sent my C.V. (curriculum vita) on line and I attended an interview." They told us that the provider had also obtained written references and a disclosure and barring service (DBS) check. (A satisfactory DBS check is required to ensure that people are protected from

Good

# Is the service safe?

unsuitable prospective employees). Staff recruitment files demonstrated that all required checks were obtained before the prospective employees were allowed to look after people living at Burwell.

A relative said that they believed their family member was supported to take their medicines as prescribed as their health had improved. Records for people's medicines were maintained and demonstrated that people were given their medicines as prescribed. Staff had access to guidance in managing people's pain, epilepsy and unsettled behaviour with the use of 'as required' medicines. Staff told us that they had received training in administering medicines and were assessed to be competent in managing people's medicines. Records viewed confirmed this was the case.

Medicines were stored securely. However, keys to medicines cupboards were kept in key safes which were accessible to people who were not authorised to have access to people's medicines. The manager and team leader took prompt action to hold the keys on their person to improve the security of people's medicines.

Requires improvement

# Is the service effective?

## Our findings

Actions had been taken to allow people to freely enter and leave the kitchen area of number 18 bungalow without restriction. The door between the dining area and kitchen area was no longer lockable. However, there were restrictions which included locked external doors and alarmed bedroom doors. In addition members of staff constantly supervised some of the people on a one-to-one basis. However, people's mental capacity to make decisions about their care had not been assessed and no DoLS applications had been made as a result. The provider told us in their PIR that this was an area for improvement. The manager confirmed that all eight people may lack capacity to make some decisions for themselves. They advised us that action was taken to improve the assessment of people's mental capacity. Advice from the local authority had been obtained to improve the provider's mental capacity assessment process. The manager stated that they had made an action to complete assessments of people's mental capacity and DoLS applications, although this action was not yet completed.

**This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Members of staff attended training in the application of the MCA. A team leader said, "I understand that people are assumed to have capacity rather than assume that they don't have capacity until an assessment is completed." They gave example of areas of where people's capacity should be assessed; this included support with taking their prescribed medicines, support with personal finances and receiving medical treatment.

Members of staff told us that they had training, which included induction training, to do their job. They said that this had improved since the change of management of the home. In addition a team leader said, "In my induction training I had my orientation pack. I read all of the [people's] care plans. I've gone through all of the policies and procedures and I'm now booked on all the mandatory courses." A senior support worker was on their induction training and was reading people's care records to get to know about people they were to be looking after.

Records demonstrated that staff had attended training in a range of subjects which included moving and handling, medicines, safeguarding people at risk, artificial feeding and supporting people who are living with epilepsy. The manager explained that where staff had not completed their scheduled training, that courses of these were booked. Records confirmed that this was the case.

The manager told us that when she started working at Burwell she found the staff were "highly stressed" and that their morale was low. A team leader that they now felt they were being listened to and said that they felt better supported. They said, It's getting better working here. This time a year ago, staff morale was 'rock-bottom'. Since [manager's name] came in this year, it has improved massively." A member of bank staff said, "It doesn't feel like a black cloud over us anymore. We've started climbing up the mountain and it's down to [manager's name] to be honest."

Staff were supervised and they were scheduled to attend one-to-one supervision sessions at least six times each year. In addition, staff were observed when at work and their performance was assessed. We saw that that where staff needed to improve their practice they were supported to do so. This included a team leader reminding care staff to support a person to walk in an upright position and improving the method of supporting a person to eat their food in a more dignified way.

The provider told us in their PIR that people, "have been involved in healthy eating choices, tasting session for introduction of new types of fruit, menu planning" and "Menu planning is now an activity for each week. We have produced pictures of foods and meals which customers [people who live in the home] then chose from to decide the next week's menu." Members of staff and records confirmed this was the case. People were provided with a range of menu options of their choosing. Consistency of food and drink were served in accordance with people's care plans and based on speech and language therapist eating and drinking guidelines. People's weights were monitored and nutritional advice was obtained from GPs and dieticians based on people's weights and nutritional needs.

Relatives told us that they were satisfied with how their family members were kept well. A GP told us that staff had responded to people's health care needs and had an understanding of these. They said, "...they [staff] are well informed with regard to the [person's] problem they have

Requires improvement

# Is the service effective?

come about." They also told us that staff referred people to the GP practice when they needed to and were satisfied with the responsible actions that staff had taken "in response to people's health needs."

The provider told us in their PIR that people were supported to maintain their health as they have accessed "regular appointments with their GP, dentist, audiology (hearing), as well as annual health checks." People were also supported to attend health care appointments to have their eyes checked. People's records confirmed that this was the case.

Requires improvement

# Is the service caring?

## Our findings

People were not able to tell us how they were being looked after but we saw that they were comfortable. When a person became unsettled, we saw that staff attended to their needs and they became more settled. Relatives told us that when they visited they always found that their family member was well-looked after. They said that they were satisfied with the standard of their family members' standard of personal care and this had maintained people's dignity. One relative added that they found staff were taking more time, and therefore were patient, in supporting their family member when they were eating their food. Another relative said, "I believe [name of family member] is being looked after well." We saw that staff were attentive to people's needs, including their emotional needs and when supporting people with eating their lunch.

A speech and language therapist assistant told us that when they visited the home, they had found that some members of staff were better than others in showing warmth and "genuine" care in their interactions with the person who they were supporting. We, too, also found that most but not all of the staff showed a caring and compassionate attitude to people. For example, when people were supported to enter the minibuses, staff missed opportunities to talk with people during the process. During the lunch time staff missed opportunities to fully engage with people in a social manner. In addition, we saw one member of staff speak to a person in a brusque manner. We brought these findings to the attention of the manager: they gave us assurances that these shortfalls would be addressed to improve the quality of people's experiences.

Members of staff had an understanding of the principles of looking after people living at Burwell. One member of care staff said, "I know we shouldn't always use terms of endearment, but we do, because we care." A team leader expanded on this and said, "The care is about providing people with the support they require. Helping them to live as independently as they are able to. To give them support in a dignified way. Taking into account their choices and preferences that they have." We saw how the team leader put their knowledge into practice when supporting a person with taking their prescribed medicines. They respected the person's decision not to take their medicines until they were ready to do so.

The home is arranged into two separate bungalows and previously these were managed as two individual homes. However, the provider told us in their PIR that "during the summer more outings have taken place with customers [people living at the home] sharing time together away from the scheme and this has allowed increased interaction between customers in the two bungalows as previously these were almost managed and staffed as separate entities." Team leaders confirmed that this was the case.

All bedrooms were used for single occupancy only and communal bathing and toilets were provided with lockable doors. People were supported to make choices about how they wanted their bedroom decorated. A team leader said, "We show people paint colours to choose from." They told us that where people were not able to verbally say what colour they would like, they interpreted people's non-verbal signs, such as smiling, and took this as a sign that the person had made their choice.

Information was publicly available in relation to advocacy services. The manager advised us that advocacy services were not currently used. Advocates are people who are independent and support people to make and communicate their views and wishes.

Requires improvement

# Is the service responsive?

## Our findings

Before the inspection we had received mixed views about how people's individual needs were responded to. A GP told us that the staff were aware of people's individual likes, their dislikes and their "normal behaviour patterns." They told us that they were satisfied in how people's needs were individually responded to. They also had positive comments about how people were supported with their communication needs; they said, "The staff seem to communicate well with the residents [people living at the home], both in terms of addressing things at a level suitable for each person and in terms of their ability to interpret responses from the residents." A relative, however, told us that, due to the turnover of staff, they considered that the new staff did not know their family member as well as staff who had left their employment. The manager told us that with the key-worker system and successful recruitment of more permanent members of staff, people would have improved relationships with staff who knew them as individuals.

A team leader told us that a key-worker system was in place whereby individual people had a named member of care staff. One of the key worker's responsibilities was to include the person during the monthly review of their care. The provider's annual reviews, however, did not include involvement of the person or their representative (although one relative told us that they had been invited to attend the review). In addition, relatives told us that they were not actively involved in making decisions about their family members' care or treatment, which included treatment by a GP. A relative added, "I've never been involved in planning [name of family member's] care."

We saw members of staff talk with people in a way that they could understand and with the use of an easy-to-read, pictorial care programme. However, we noticed that on one occasion, a member of care staff failed to response to what a person was telling them. The person was telling them, by non-verbal communication and sign language, that they did not want to eat any more of their lunch. The member of staff failed to respond to the person's communication needs as they continued with supporting the person to eat more of their food. We have brought this to the attention of the manager.

The provider told us before the inspection that the use of communication boards to support people with their communication difficulties had decreased due to a turnover of staff. The provider told us that this method of communication was to be re-introduced. We saw that action was taken to re-introduce different communication methods. Members of care staff had access to picture guidance, and training was in progress, in how to interpret what people were saying to them by means of sign language and how to use this method of communication. The manager advised us that they were in consultation with a speech and language therapist to introduce 'talking mats', which is another communication aid.

People's health were responded to and these included continence and mobility needs. People's social needs were also supported as they had access to a range of recreational and work-related activities. These included walks, shopping, visiting relatives, voluntary work, college courses, arts and crafts and swimming. There were also organised activities at home which included massages and indoor games.

People's care records detailed people's life histories and care plans and risk assessments were kept up-to-date and reviewed. Changes in the records were made in response to people's needs. This included changes in people's health conditions and the risks to their health.

There was a complaints procedure in place and two relatives knew who to speak with if they were unhappy. One relative told us that they had made a concern known and said, "They really tried to sort it (concern) out." There was a complaints procedure in place and members of staff were aware of how to support people with making a complaint. A team leader told us that it was during the monthly key worker review that people were asked if they were happy or not. Information was publicly available and in easy-to-read format in relation to the complaints and safeguarding people at risk procedures.

Good

# Is the service well-led?

## Our findings

A registered manager was not in post when we visited and the current manager's application to be registered was in progress. We received positive comments about the leadership style of the manager. A team leader said, "[Name of manager] will listen to ideas from staff. Staff training has improved greatly since she has come in. She's very supportive and understanding and non-judgemental. Her knowledge of training is vast." A relative said, "I do worry that [name of family member] is not always getting the care that she needs and perhaps the care that she needs is not always possible. But now they have sorted out the manager side of things they seem to have got people [managers] on the ball."

We saw the manager walking around the home and she spoke with people and staff. During this time the manager informed staff that there were no limited times when people could have a drink. The manager explained that this was an example of how they intended to change the culture of how people were being looked after. Another example they gave was to involve people more when their meals were being prepared.

The manager operated an open culture within the home. Members of staff were aware of the whistle blowing procedure. A team leader said, "Whistle blowing is if I have concerns or feel something is not right. I can use the whistle blowing line and report it to the local authority and CQC." Another team leader also told us the same and said that they would have no reservation in blowing the whistle if they needed to.

The provider sent their PIR when we required it and the information within this told us there were quality assurance systems in place to monitor and review the quality and safety of people's care. Examples were given to demonstrate how people's health was maintained and how they were actively involved in menu planning. The provider had also identified improvements that were to be made during the next 12 months, which included increasing the range of training for staff to attend, such as training in autism and nutrition.

The manager advised us that there were planned improvements in relation to the moving and handing risk assessments. These were to be developed to contain clearer guidance for staff once the manager had received their refresher training in moving and handling. They also told us that there was a review to improve the range of indoor activities. This was to promote people's sense of well-being and, therefore, reduce the inappropriate use of the television, which we saw few people were interested in.

Staff meetings were held at least every two months during which staff were reminded of their roles and responsibilities, for instance, in relation to record keeping and improving the standard of people's dining experiences. A team leader said, "Recording is improving and staff are writing more about people's daily activities and their general health and well-being." We also saw examples of how staff applied this information from the manager into practice. Detailed care records were kept-up-to-date and staff were aware of promoting people's dignity when eating their food.

The manager told us that people had attended house meetings although these were not recorded. People were provided with other opportunities to share their views during their monthly reviews. Surveys had yet to be carried out to obtain people's views; the manager advised us that these were planned to be carried out during March and April 2016.

People were integrated into the community. They had access to shops, community parks and there were opportunities to work as a volunteer in a local industry.

There was a quality assurance system in place. The manager told us that their manager, an area manager, visited the home at least every six weeks during which time audits were carried out on a number of areas. Records of these were made and detailed findings in relation to staff training, health and safety checks, staff meeting minutes and policies and procedures. A team leader was responsible for carrying out audits on people's medicines and this had improved the methods of recording and reduction in medicines errors. Action was also taken to improve the refurbishment and redecoration of the kitchen areas and bath rooms. Attendance in staff support and development had improved and staff told us that people were now receiving improved quality of care and that they were safer. A team leader said, "People seem happier. There's a lot less disruptive behaviour, more smiles and people seem more happy in their demeanour."

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br><br>The provider was not acting in accordance with the requirements of the MCA including the DoLS. |