Complete Care Services Limited

Quince House

Inspection report

77 Adeyfield Road
Adeyfield
Hemel Hempstead
Hertfordshire
HP2 5DZ
Tel: 01442 248316
Website: www.completecare.org.uk

Date of inspection visit: 14 November 2014
Date of publication: 19/05/2015

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

Overall summary

Summary of findings

This unannounced inspection was carried out on the 12 November 2014.

Quince House provides accommodation, support and treatment for up to six people living with learning difficulties. At the time of the inspection there were five people living in the home.

The service has a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had effective recruitment processes in place, and there were sufficient staff employed however they were not always deployed effectively on a day to day basis.

Summary of findings

People's needs had been assessed, and care plans took account of people's individual care and treatment needs, preferences, and choices. However, people's records were not always up to date with relevant information.

There were risk assessments in place that gave guidance to the staff on how risks could be minimised. However these were not always up to date. There were systems in place to safeguard people from the risk of abuse and medicines were managed safely.

The staff had appropriate training, supervision and support, however they did not fully understand their roles in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were supported to have sufficient food and drinks in a caring and respectful manner.

People were supported to access other health and social care professionals when required. However the home did not always use the services available in the community effectively. The people were supported to continue their relationships with their family members and friends.

The provider had a formal process for handling complaints and concerns. They encouraged feedback from people and acted on the comments received to improve the quality of the service.

During this inspection we found the service to be in breach of one of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. 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?

Requires Improvement

The service was not always safe.

People and their relatives told us that the home was safe. People were relaxed and interacted freely with the staff that supported them.

Medicines were managed safely.

Staff were recruited safely and trained to appropriately meet people's needs. There were enough staff to provide the support people needed, however they were not always appropriately deployed on a day to day basis.

Safeguarding guidance enabled the staff to raise concerns when people were at risk of abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not have a good understanding of their responsibilities under the Mental Capacity Act 2005 (MCA), and the associated Deprivation of Liberty Safeguards (DoLS).

People were supported to eat sufficient and nutritious food and drink.

People did not always have access to other community based social care services.

The staff had received regular training, supervision to enable them to effectively meet the needs of the people they supported.

Is the service caring?

Requires Improvement

The service was not always caring.

The staff did not always respect people's wishes and choices and their dignity and privacy was not always promoted.

The staff we spoke with demonstrated that they knew the people they supported well and that they understood their needs.

Relatives were encouraged to visit whenever they wanted.

Is the service responsive?

Requires Improvement

The home was not always responsive.

Care was delivered in an individualised manner and people's needs had been assessed, however the information in the care plans was not dated and signed.

The service encouraged some of the people to follow their hobbies and interests.

Summary of findings

Due to the small size of the home complaints and issues of concern were dealt with swiftly and informally without the need to escalate further.

Is the service well-led?

Requires Improvement

The home was not always well led.

The quality systems in place did not always recognise areas for improvement.

People who used the service and their relatives were enabled to routinely share their experiences of the service.

The staff were not always listened to and their views in relation to the welfare of the people were not acted on.

Quince House

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 12 November 2014 and was unannounced. The inspection team made up of one inspector and a specialist advisor with expertise in care of people who are living with a learning disability.

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 contacted health and social care professionals who regularly visited the people who live in the home. We received feedback from three health care professionals.

We reviewed the information we held about the provider. We looked at the notifications that the provider had sent us. A notification is information about important events which the provider is required to send us by law. We looked at the report of the previous inspection conducted in September 2014.

During our inspection we spoke with two people who lived in the home and the relatives of two people. We observed the interaction between two people who did not have verbal communication skills and the staff. We spoke with the deputy manager and three care staff. We reviewed the care records of three people we observed as having complex needs, and training records for all the staff. We also reviewed how the manager monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

One person told us they felt safe and had confidence in the care workers that assisted them. Relatives said they did not have any concerns about the safety of their family members while care workers were supporting them. We saw that the people who did not have verbal communication skills were relaxed and comfortable with the staff.

Discussions with care workers and a review of records showed that they had received training in safeguarding adults during their induction and had regular ongoing training. Staff knew the different types of abuse and were aware of their duty of care to the people. They were confident about who they should report abuse to and told us that would follow up any allegations until they were happy it had been investigated. Staff were aware of whistleblowing and knew the agencies to approach should they need to.

Staff had been trained in the administration of medicines, and records showed that their competency to administer medicines safely was assessed. We looked at the medicine plans and the administration and monitoring systems that were in place for people. These showed that medication was stored, administered and recorded effectively. Each person had a lockable medicine cupboard in their room. We saw that the people were taken to their room so that they had their medicines administered in private. Two members of staff were present to ensure errors were not made. We saw that people were given their medication in an unhurried manner and that staff encouraged them to take it. A review of the Medication Administration Records (MAR) showed that they had been completed correctly. The MARs were audited regularly and action plans were in place when any issues were identified. We were told that as two staff were present during the administration of medicines errors were spotted immediately.

Although individual risk assessments had been completed for people, some were not dated and signed which made it difficult to know if the information was current. This included information that would accompany the person should they need to go to hospital. However, staff told us that they knew the five people who lived in the home very well and knew all their on-going health needs and that a staff member would accompany a person should they need to go to hospital or to a medical appointment. Individualised risk assessments were carried out to make sure the people were safe both in the home and in the community.

Incidents that had a detrimental effect on people's health were recorded and reviewed. One action that resulted from these reviews was to provide protective equipment for some people. Risk assessments had been carried out on the environment. This included the storage and use of fresh food. There were systems in place to ensure food was used within its sell by date and that food was dated on opening. The home had an emergency plan in place should the home need to be evacuated. Staff knew what to do in the event of a fire in the home.

However we found that some risks were over managed. For example one person who liked going into the garden was not allowed to do this as it had just rained and it was feared that they might slip and fall. This meant that they were limited in their use of the garden and the swings and trampoline they liked to use. Incidents were reported appropriately to the Care Quality Commission and to the Local Authority.

We found that recruitment practices were safe and that the relevant checks had been completed before staff worked with people in their homes. This included up to date criminal record checks, fitness to work questionnaires, proof of identity and right to work in the United Kingdom and references from appropriate sources, such as current or most recent employers. Staff had filled in application forms to demonstrate that they had relevant skills and experience and any gaps in employment were explained. This made sure that people were protected as far as possible from individuals who were known to be unsuitable.

There was enough staff on duty, however they worked long shifts of up to 14 hours and sometimes they did not take a break. We were told that if some staff were out of the home supporting a person it was difficult to take a timely break. Other staff said that they did not want to take a break as they said that 'there was nowhere to go.' This meant that sometimes they worked for their full shift without a break. No risk assessment had been done on staff working these long hours to explore if it had an impact on the people they supported, most of whom had very complex needs. One

Requires Improvement

Is the service safe?

staff told us that sometimes they found the working day very long and struggled to stay awake, especially if they have been supporting a person outside in the fresh air for most of the day.

Requires Improvement

Is the service effective?

Our findings

Relatives felt that overall care workers had the right skills and knowledge to meet people's needs. One relative said, "From what I've seen they seem very expert at what they do".

All care workers completed an induction that was based on Skills for Care Common Induction standards, which are nationally recognised induction standards. Care workers we spoke with had a good understanding of their roles.

Care workers completed the provider's compulsory training such as infection control, moving and handling, medicines management and emergency first aid. They had also been provided with specialist training to meet people's specific needs. For example, they had been trained to care for people who had seizures. All the staff told us that they felt that they training prepared them for the care they had to deliver and to support the people to have a fulfilled life.

There was a mixed response from care workers as to whether they felt well supported and supervised by the provider. Most felt that they were well supported. The provider's supervision policy stated that staff would have at least four supervision (support and development) sessions a year. Staff confirmed that they have these regular supervision sessions and that they were invited to identify their training needs and to reflect on their practice in supervision with their manager.

Some staff were not happy with the long shifts and felt that they had no option but to complete them.

Most of the people did not have an understanding of care planning and were assisted in this by their families. However where possible people were involved in their life planning. Examples of this were planning a holiday last summer and identifying the hobbies they liked to pursue. Other day to day care delivery was done with the involvement of the people. People's relatives told us that they were involved in their care planning and we saw that they had signed the care plans to indicate that they agreed with the planned care. Relatives we spoke with told us that they were always consulted when there was a need to change care plans or the person's routine in the home changed.

Where people did not have the capacity to consent to their care or treatment, we saw that mental capacity assessments had been completed and a decision had been made to provide care or treatment in the person's best interest. This was done with the person's family and representatives in line with the Mental Capacity Act 2005. Records showed that assessments of people's capacity to make decisions had been carried out, where decisions regarding care and treatment were required. Where people had been assessed as not having capacity to make a decision, the appropriate steps had been taken to involve family and or an advocate. However we saw that despite limitations being put on people's freedom to come and go as they please, they did not have the documentation to support an application for Deprivation of Liberty Authorisations (DoLS). This did not meet the requirements of the Mental Capacity Act 2005 (MCA). Care workers had been trained in the MCA during their induction and those we spoke with had a basic understanding about this and making decisions that were in people's best interests. Staff were aware of the policy around obtaining consent and where possible consent had been obtained.

Staff told us and we saw that they always sought people's consent before completing any care or support tasks. However, we saw that, when one person was enjoying a snack, a member of the care staff insisted that it was time to conduct an activity that the person clearly did not want to do. The staff member continued to make the suggestion although the person clearly wanted to finish their snack which they did before responding to the staff. This interaction had taken away from the person's enjoyment of their snack.

We saw that people were supported to have enough to eat and drink and at the times they wanted it. All the people were able to show when they wanted to eat or drink. We saw that staff and the people ate together. Staff made meal times an enjoyable event as they chatted with people while they supported them to eat. The staff assisted people at a suitable pace and did not rush them. None of the people had nutrition issues and all were able to eat and drink unaided. Some people were having their weight monitored and the home was working with advice from a dietician to ensure they maintained or gained weight.

People's health needs were assessed and planned for to make sure they received the care they needed. People had access to physical health, mental health and social care professionals. All the people were registered with a local GP practice and had access to dentists, opticians. Some of the

Requires Improvement

Is the service effective?

people were very anxious about attending the dentist and the home had worked with one dentist to ensure they build up a relationship between them and the people. We were told that this had started to make the process less traumatic for people.

Requires Improvement

Is the service caring?

Our findings

Throughout the inspection we saw staff were treated the people with kindness and compassion. One person told us staff were 'kind and ok.' One relative said, "All the carers are good, they are all lovely and treat [relative] well." Another person said, "I'm very happy with the care they are all wonderful, they treat [relative] very well, I can't praise them enough." Most of the people who lived at the service had limited verbal communication skills. However we noted that the staff were able to understand people's needs and requirements and had established effective communication skills. Staff interacted effectively with people and we noted that they spoke to the people and smiled at them told them what they were doing before assisting people with a task. This created a relaxed atmosphere in the home.

Relatives we spoke with confirmed that they were involved in making decisions about their relative's care. We observed care workers giving people choices about the support they wanted. For example, we saw that one person had the choice over day to day decisions such as when they got up and went to bed. Another person said that the staff were 'nice' and that they "Helped me to get ready to go out." We saw that staff promoted people's privacy and dignity throughout the inspection. However we saw an incident where the person's dignity was not supported we saw that a staff member focused on tasks rather than on supporting the person with their immediate needs or wishes. The staff member repeatedly called out, from a different room, that it was time for one person to use the toilet. The person showed signs of irritation but as the staff member couldn't see this and they carried on calling for the person and this increased their irritation.

People had the choice in how to decorate their rooms. We saw that all their rooms were individualised and reflected their taste. However one person's bedroom led directly off the main sitting room and throughout the inspection this door was left open. This meant that anyone in the home could see directly into the room reducing the person's right to privacy. We were told that the person preferred this although it was not documented in their care plan.

Requires Improvement

Is the service responsive?

Our findings

The people who lived in the home had complex needs and not all of them were able to participate in planning their care. However we saw evidence that people's families were involved in care planning where this was appropriate. Care plans were detailed and contained good information to assist staff to meet people's needs. There was an easy read "support consent form" these had been signed by family members and covered all aspects of the persons care, treatment and support including being assisted with medication, and management of finances. Families told us that as the home is so small and the turnover of staff low, that, "Staff know the people well and understand their needs through their body language."

All of the people had their physical needs assessed and met. Records were kept and reviewed in relation to people who were prone to health issues such as seizures. A review of records showed that where the pattern had changed medical support was sought and advice followed. We saw that reviews of the person's care were held regularly and family members were invited to attend. Every effort was made to arrange review meetings on a convenient date to enable the family members who knew people well to attend. We saw that dates had been changed several times to accommodate them. Families we spoke with confirmed this.

Most of the people were supported to pursue work or hobbies. This included arranging for other agencies to take people out for sporting and social events. However some people had a very limited life outside the home and they were not always stimulated while in the home. We saw that they had access to a small number of battery operated children's toys which we saw gave them comfort. However there was nothing else freely available to the people to stimulate and occupy them. Three of the five people were out of the home pursuing paid work or their hobbies for part of the inspection. When they returned we saw that staff welcomed them home and they told us that they had a nice day.

The provider had a complaints policy in place. We were told by relatives that as this is a small home and they know the manager very well, concerns were resolved with "a quick word" without the need for a formal complaint. The people we spoke with said that they would be able to make a complaint if they needed to. They said that they were sure that [the manager] would sort it out as quickly as possible. There were no outstanding complaints at the time of the inspections.

Requires Improvement

Is the service well-led?

Our findings

Relatives told us that the manger was easy to talk to and included them in the running of the home. This ensured their relatives were cared for in a manner that suited each person. We were told that the manager was available and was easy to talk to and listened to them. They were welcomed into the home at any time. They said that the manager promoted the rights and welfare of the people in an open and inclusive.

Relatives told us that they completed a questionnaire on an annual basis, but they said that this was “almost unnecessary” as they felt they were included on an ongoing basis. One relative told us that [relative] was very happy in the home and that they felt that this was mainly down to the manager who ran the home in the ‘best interests’ of the people who lived there. However we found that links with the local community were not always fostered.

The home had a stable workforce, including the manager and the assistant manager, who had worked there for many years. Most of the staff told us that they felt supported by the manager and the deputy manager. Some felt that they were not listened to when they wanted to change their shift pattern. However the staff told us that the manager was easy to talk to and to get on with and other than that one issue they felt well supported. Staff worked well as a team and were aware of their responsibilities and accountabilities to the people.

This is a small home where people were supported by a core of established staff, who worked well together and knew the people very well and could recognise their needs and wishes. However this was not always supported by robust paperwork and record keeping. Staff relied on their knowledge of the people to provide good care. This meant that emergencies such as staff absences where there was a need to use agency staff were not planned for.

Audits were in place for all aspects of the service but they were not always completed. For example an there was an audit in place for reviewing care plans and we found that they contained information that was out of date and contained conflicting information. Risk assessments were not always dated and signed and there was no risk assessment in relation to the long hours staff worked without a break and the effect this had on them and the people they cared for.

The provider had not replaced damaged furniture in the sitting room, instead we saw that it was patched and repaired. However the repairs were clearly visible and this took away from the dignity of the people.

The home had a whistle blowing policy that all staff were aware of and some staff had used it to raise concerns in the home. These were investigated and found not to have substance.

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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People who use services were not protected against the risks associated with not having a robust system in place that assess and monitors the delivery of the service.