Orbit Group Limited

Saxon House

Inspection report

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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?	Good
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 11 June 2015 and was announced.

Saxon House provides support to older people. They have their own tenancies and are provided with care in their own flats within Saxon House. As such, the safety of equipment and facilities within people's flats is not within the remit of this inspection but is the responsibility of the landlord or tenant.

There was 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.

At the last inspection of this service in September 2014, we found that medicines were not managed safely. At this inspection we found that improvements had been made. Medicines were stored safely. The staff team completed regular checks so that omissions, from either records or of medicines given, were identified and addressed promptly.

Summary of findings

Staff knew the importance of recognising, responding to and reporting any indications which might indicate a person had been abused or harmed in some way. However, emerging risks had not consistently been taken into account to ensure people's safety in the service and gaps in the process of assessing people's needs compromised this further.

Staff were competent to meet people's needs and had developed a good understanding of people's preferences and wishes. They ensured they sought advice promptly on behalf of people who became unwell. Staff understood the importance of supporting people to have enough to eat and drink where this was a part of their care package or when their health changed. The provider had identified that some further training was needed. This was to ensure that staff fully understood how to support people who may find it difficult to make informed decisions about their care.

Staff supported people in a manner that ensured their privacy and dignity was respected. People were consulted about their care, with support from their family if they wanted or needed this. Staff responded with warmth and kindness to people's requests for assistance. There was a cheerful and sociable atmosphere within the service.

People could raise complaints or concerns about the quality of care they received and have these addressed. People were also enabled to express their views about the way staff supported them and were satisfied with the care they received.

Systems for monitoring the service did not properly identify where improvements or further investigations were necessary in the interests of people's safety and welfare. Systems also did not ensure that information about incidents was passed promptly to the Care Quality Commission when this was required.

We found two breaches of regulations. The registered persons did not ensure that systems for monitoring service quality and safety were implemented robustly. They had also failed to notify the Commission of a specific event happening within the service. 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 not consistently safe.

Risks to people's safety were not always properly assessed and appropriate advice taken promptly to promote their safety and welfare.

People were generally supported by sufficient numbers of staff but changing needs and dependency meant that it was sometimes difficult to assist people promptly.

Systems for managing medicines had improved.

Requires Improvement

Is the service effective?
The service was effective.

People's needs were met by staff who were competent and properly supported to deliver care. Staff took prompt action to seek medical advice when people were unwell and provided assistance for people to eat and drink enough if this was required.

The provider had identified that some further training was needed for staff to support people who may lack the capacity to make informed decisions about their care.

Good

Is the service caring?
The service was caring.

People were involved in decisions and choices about their day to day care.

Staff respected people's privacy and dignity and people valued the caring approach shown to them by staff.

Good

Is the service responsive?
The service was responsive.

People's needs were assessed before they started to use the service. A shortfall in information for one person was addressed during the inspection.

People's concerns or complaints about their care were listened to and acted upon.

Good

Is the service well-led?
The service was not consistently well-led.

The provider's systems for monitoring and improving the service people received and for mitigating risk were not wholly robust and effective.

Requires Improvement

Summary of findings

The registered manager and provider had failed to notify the Commission promptly about an incident taking place within the service, as required by their registration.

Saxon 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.

The inspection took place on 11 June 2015. The provider was given 48 hours' notice because the location provides a domiciliary care service to people in their own homes. We wanted to ensure that relevant staff would be available to talk to us. The inspection was carried out by two inspectors.

Before we visited the service we reviewed the information we hold about it. This included information about complaints and specific events such as incidents taking place within the service. The provider is required by law to notify us of these, including events affecting people's safety or accidents occurring to people while they are receiving care. We also checked with the local authority's quality assurance team to ask for their views.

We spoke to ten people who used the service and three relatives. We also spoke with four members of staff and the area manager. We observed the way that people were supported.

We reviewed care records for four people, including medicine administration records. We looked at records associated with the running of the service including medicines audits and quality assurance checks. We reviewed the information within minutes for tenants' meetings and staff meetings.

Requires Improvement

Is the service safe?

Our findings

At our inspection in September 2014, we found that the service was not consistently safe. This was because medicines were not always stored safely. Some staff needed training to administer medicines safely and their competence to do this was not properly checked. The provider told us what they were going to do to improve and at this inspection we found that action had been taken.

One person told us, "They [staff] give me my medication at the right time, which relieves me of the responsibility." Another commented that staff administered their medicines and they had no concerns about the way this was done.

We found that storage arrangements had been reviewed to ensure that people had sufficient secure storage for the medicines they needed. There were regular daily checks on medicines to identify whether they were any missing signatures or whether medicine had been missed for any reason. This enabled concerns to be identified and remedial action taken promptly. A senior carer told us about further improvements that were planned to records for audits of medicines received in the service for tenants and managed on their behalf by staff.

Staff had received updates to their training to administer medicines. From discussions with a senior member of staff and a review of records, we found that any concerns about the way staff administered medicines were addressed promptly. This meant that the safety of systems for administering medicines was monitored and improved where necessary to ensure people received their medicines as prescribed.

We found that one person's medicine administration record (MAR) chart showed they were to have a particular cream administered twice daily to assist in the prevention of pressure sores. Their MAR chart did not indicate that this was happening. However, a senior member of staff was able to tell us that the person's skin had improved and that they no longer had a pressure ulcer. They told us that they would discuss this with the doctor or district nurse to see if it could be used only when it was needed because the person's condition had changed.

We found that risks to people's safety were not consistently and robustly assessed when there were emerging concerns. This was particularly where people had difficulties understanding and choosing to accept the risks to which their actions exposed them. We found that guidance about risk for one person lacked detail but staff were able to tell us about the times of day they needed to take a particular course of action to promote the person's safety. We noted that this had not been entirely successful and the person had continued to place themselves at significant risk.

We also identified that urgent action was needed to address concerns about the safety of another person because of the danger presented. Staff were not able to locate information to show that the risk had been assessed following incidents and how it was to be addressed in the interests of the person's safety. Action was taken when we raised our concerns but had not been initiated in response to events. The area manager ensured a risk assessment was completed straight away. This led to improving staffing levels pending a resolution of the situation so that staff were more likely to be able to intervene promptly. A safeguarding referral was also made as it was clear that the person had not been properly protected from serious risk of harm and action was needed to ensure their safety and welfare.

People told us they felt there were enough staff to ensure their safety, although sometimes they had to wait unless it was an emergency. One person said, "At a push there's enough staff but they're busy." They went on to say that "If you want something, you may have to wait but they do come." Two people did say that in an emergency, staff responded well. One commented, "When I've used my call bell they've come quickly." Another told us, "The staff are there if anything happens."

We noted that one person's health had deteriorated over the two days leading up to our inspection so that they were requiring considerably more support. This included the need for assistance from two staff to reposition them safely. Another person also needed assistance from two staff as they remained in bed. At certain times of the day, for example during the evening, this meant that two staff could be engaged in assisting a person and that the remaining tenants would need to wait for assistance. Staff said that they did not feel staffing levels were unsafe but sometimes this did make it difficult to respond to people promptly.

There were no recently appointed staff on duty with whom we could discuss recruitment procedures and establish whether these contributed towards protecting people.

Requires Improvement

Is the service safe?

However, the area manager told us that people were not confirmed in post until appropriate checks had been made. This included taking up two references and checking to make sure they were not barred from working in care. They also described the interview process and explained how applicants were selected for appointment. The area manager told us that gaps in employment history were explored at interview and the application form asked for referees who could account for the applicants last three years' employment history.

People told us they had no concerns about their safety. One person told us, "The staff are alright. They treat me very well." Another commented, "I feel safe. I'm never frightened to ask them [staff] for something."

Staff confirmed that they had training to enable them to recognise and respond to any suspicion of abuse. They told us that this was renewed regularly. They were able to give us examples of what might cause them concern and were clear about their obligation to report issues promptly. One staff member was unclear about reporting a concern outside the service if they were unable to raise it with more senior staff. However, they were able to identify where they could find further information and guidance if it was needed.

We noted that equipment provided by the service was tested and serviced regularly. This included regular testing of a hoist for shared use and of electrical equipment. Staff were able to tell us where to report in the event of the fire alarm sounding and confirmed that it was tested regularly to ensure it would work properly in an emergency. We found that the safety of communal areas was checked and repairs made. This helped to ensure people's safety. We saw that people had their call bells accessible to them so that they could summon assistance when they needed it.

Good

Is the service effective?

Our findings

A relative commented that there had been problems with the abilities of staff to meet someone's needs when they first started to use the service. They said, "There were teething problems at the start. We put it down to not knowing [person's] needs. Everything is fine now." Another visitor said, "[Person] has her general needs met very well."

The service provided was for 'independent living' to people with their own tenancies. As such, most people using the service had the capacity to make decisions for themselves. One person told us, "They [staff] always ask me before helping me." People told us that they felt they were well supported by staff and that staff knew how to assist them. For example, one person commented, "I'm completely happy with the staff." Another person said, "I get what I require."

Staff told us that they did not have specific training about the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS). However, they said this was linked to other training they received such as safeguarding and moving and handling. Staff were able to tell us how they respected people's choices and offered them explanations about their care. There was some confusion about how to apply the provision of the DoLS within the service and when and how an authorisation should be sought to ensure the rights of people whose capacity was in doubt were not infringed. However, the area manager had already identified this as an area for development and had alerted the provider that this was needed.

Staff said they had plenty of opportunities to receive training. They all confirmed that they received relevant training to assist them in their duties, including regular updates of core training such as moving and handling and first aid. Some training was by e-learning and other was class-room based. They said that they were looking forward to having some more training in dementia awareness from the manager who had recently completed a course to assist with this.

Staff confirmed that they received regular supervision and support, including appraisal of their performance. We noted from discussion with a senior member of staff and associated records, that the competency of staff to administer medicines was assessed to ensure they had the required skills. The area manager told us how a review of training had been carried out recently to see what further training would be of benefit to staff in their work with people.

Discussions with staff and a review of daily records showed that staff arranged for people to see other professionals who could help keep them well. This included appointments with their doctor and the district nurse when this was needed. One person said, "If I am unwell, they do what's necessary." We observed the staff hand-over which showed they were aware of who was unwell and needed to see their doctor. We noted from their discussions that one person had become unwell overnight and that the doctor had been contacted promptly for an appointment.

People were able to prepare light meals such as breakfast or sandwiches in their flats. Staff support was offered if this was a part of their care package. One person told us that, "Staff prepare my dinner for me." Staff were aware of the importance of ensuring that people had enough to eat and drink to promote their health. The provision of main meals was not a part of the care service but staff provided people with assistance in the restaurant if this was needed. They monitored people's food and fluid intake where appropriate. The amount people drank was not always recorded in detail although there were no concerns that fluid levels were insufficient as they were being assisted regularly to manage continence. We observed that staff offered people drinks frequently. Staff were aware of one person who needed additional encouragement to drink, particularly as they were unwell. We also saw that staff ensured people always had a drink within their reach, including one person who remained in bed.

Good

Is the service caring?

Our findings

People told us that they felt well cared for by staff. One person said, "I've been treated beautifully." A relative commented that staff were "…very helpful and obliging."

We saw that staff responded to people in a respectful and kindly manner. There was a lot of chatter, smiles and laughter between staff and people. We also noted that staff intervened promptly to relieve one person's discomfort. This was where most people said they were enjoying the fresh air from having conservatory doors open but one person felt this was cold. A staff member asked whether the person would like them to fetch a cardigan and went to get this promptly. We also observed that another member of staff intervened quickly to assist someone who was confused. The person was unsure of where the dining room was and whether it was time to go there for their meal. The staff member offered reassurance and gently guided them in the right direction.

People told us that they were involved in decisions about their care. One person said, "I am involved; very much so." This was confirmed by a visiting family member who said they would also be consulted about their relative's care. Another person told us, "They talk to me about what help I need. They do that about once a month." Although there was limited information about people's preferences, histories and backgrounds within their care records, our discussions with staff showed that they were aware of these. They spoke warmly of the people they supported.

We also saw that one person was encouraged to be as independent as they could be with their mobility. While they were going to the restaurant using their walking frame, staff provided assistance and encouragement. This included prompting them to make sure that they kept the frame within a safe distance and did not over-reach themselves.

People told us that they felt staff respected their privacy. For example one person said, "Staff always use the bell on entry" and, "They are always very pleasant when they come in." We saw that this happened and that staff let people know who they were when they entered people's flats.

Staff told us that they received training in equality and diversity issues so that they would understand how to support people with differing needs and values. They were able to give us examples of how they promoted people's privacy and dignity when they entered people's homes and while they were delivering personal care. This included ensuring that people were appropriately covered and also that their curtains and doors were closed when this happened.

Good

Is the service responsive?

Our findings

We found that people had their needs assessed. This process involved people who were intending to use the service and their family members where appropriate. Where the local authority was involved in arranging the service, an assessment was also obtained from them. However, we noted that for one person, there was no follow up with the last service they used to clarify the person's needs. This compromised the ability of staff to support the person properly because they were not aware of some of their support needs. The decision about whether the service would be able to meet the person's needs well and safely was not based on full information. Action was taken to provide further information and guidance for staff while we were present.

One person told us that they felt the service had responded to their changing needs well. They also told us, that when they had asked for help, "[The manager] did what I asked her to do." For another person whose needs had changed three days before our inspection, although their plan of care had not yet been updated, the service had responded by increasing the support that staff offered. This meant that the person was receiving additional support and monitoring to eat and drink and to minimise the risk of developing pressure ulcers. Staff had also sought advice from the person's doctor. This showed that staff responded flexibly when a person's needs changed.

People's plans of care were focused on the support that was needed at each visit and the timings of those visits. A staff member said they did not all contain people's personal histories and preferences and we confirmed this in records sampled. Despite this, many of the staff working in the service had been there for a long time and said they had got to know people's histories and preferences well. They were able to tell us about these and gave us examples. We concluded that the way staff delivered care was focused on each individual. Records showed that the manager checked samples of plans of care to ensure they were kept up to date.

People did not receive staff support within their own flats to follow their preferred hobbies and interests. However, staff did support them to engage in group activities if this was their need and preference.

People told us that they did not have any complaints about their care. People told us that they felt they could raise concerns or complaints. Only one person was not sure who they would go to if they had a complaint but would ask staff. A visitor told us how they had raised one minor complaint which they said was responded to very well. Another visitor said, "If there's a problem, they just sort it." They went on to tell us that they knew who to speak to if they had concerns and felt comfortable about doing so. They said that the care of their relative had improved after they raised an issue.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post, sharing responsibility with the provider for delivering the service and for complying with regulations. However, we found from discussions that led us to review daily notes, that there had been an incident reported to the police. Neither the provider nor the registered manager had notified the Care Quality Commission (CQC) of this so that we could monitor the action the service was taking in relation to safety. **This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.**

We found that systems for ensuring people received high quality care were not sufficiently robust. The provider had recording forms in place for monthly audits. These were designed to include checks on aspects of the service such as sampling plans of care, reviews held, incidents, staff supervision, appraisal and training. We found those completed lacked detail so that they did not ensure that the standard of care and records was checked thoroughly to see where improvements were needed. For example, in November 2014 the record of the audit was only partially completed. Some entries in other audits in relation to supervision records and checks on care plans just recorded "sampled." They did not show whose records had been checked to ensure that all of these were checked over time and were up to date. We showed the audits of concern to the area manager who agreed that these did not contain the expected level of detail to show the service was robustly monitored and assessed.

Although there were regular audits of medicines completed by staff to ensure errors were identified promptly, the manager's review of these was not used to analyse patterns of concern and had stopped in March 2015. Although medicines errors were picked up within regular audits, the manager's audits had not identified that these mistakes (predominantly in recording of medicines) were increasing. More than 20 errors or omissions occurred in May 2015, based on the regular audits we reviewed. This showed a significant increase above the single figures identified in the manager's analysis earlier in the year which had not been investigated.

This raised concerns that systems for assessing, monitoring and improving service quality and mitigating risks to people's health, safety and welfare, were not effective. **This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.**

We received conflicting views from people using the service and the staff, about how visible and accessible the manager was to them. For example, one person using the service said, "I don't see the manager very much." Another person told us, "[The manager] is here most days but I don't see her often." However, people told us that there were regular meetings for tenants to express their views about the quality of the care they received. Staff said that they felt the manager was approachable and that they could go to her with issues. They said that they were able to contribute to the agenda for staff meetings and so could raise issues that were important to them. All of the staff spoken with described the care staff team as working well together, being good at ironing out problems and having good morale. In our discussions with them they showed they had a clear understanding of their roles and responsibilities.

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
Personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered persons had failed to notify the Commission without delay of an incident reported to the police. Regulation 18(1) and (2) (f)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems for monitoring the quality and safety of the service and assessing and mitigating risks to people were not implemented effectively. Regulation 17(2) (a) and (b)