Clacton Family Trust

Clacton Family Trust

Inspection report

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Ratings

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

Overall summary

The inspection took place on 28 and 30 September 2015 and was unannounced.

Clacton Family Trust provides accommodation and care for up to 37 people with a learning disability and physical disabilities within five bungalows. At the time of our inspection there were 35 people using this part of the service. Clacton Family Trust also provides personal care to people living in supported living units. People who use this part of the service have their own tenancies and receive their support from staff employed by Clacton Family Trust. At the time of our inspection there were 21 people in supported living, in a property with 15 flats and the remainder in properties within the local area. There were a further three people receiving support in their own homes.

A registered manager resigned from post in the week of our inspection. 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

Summary of findings

meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Following our visit, the provider made arrangements to appoint a new registered manager.

There was a difference in the quality of care between the supported living service and the care home, which were run as two separate services. Whilst we found that people at the supported living service received a good service, the experience for people at the care home was not consistently good. Throughout this report we will aim to distinguish, where relevant, between the two different parts of the service.

There were measures in place to manage and minimise risk. There were sufficient numbers of staff available to meet to keep people safe. The service constantly reviewed the effectiveness of their staffing arrangements to ensure people's needs were met.

There were systems in place to manage medicines and people were supported to take their prescribed medicines safely. The provider had a robust recruitment process in place to protect people from the risk of avoidable harm.

Staff supported people to have sufficient food and drink that met their individual needs. People's health needs were managed by staff with input from relevant health care professionals. People's independence was promoted by staff and they were involved in decisions about their care.

People were treated with kindness, dignity and respect by staff who knew them well and their rights were upheld. Staff had the skills to support people to communicate their views and preferences, however they did not always make use of a wide variety of communication methods when communicating with people. Detailed assessments had been carried out and personalised care plans were in place which reflected individual needs and preferences, however people were not always supported to engage in meaningful activities. The provider had an effective complaints procedure and people had confidence that concerns would be investigated and addressed.

The provider was in the process of arranging for a new registered manager to be in post. The provider and deputy manager were committed to improving the service, however more time was needed to measure whether their proposed changes were positive and sustainable. The service was not able to demonstrate that the current systems in place to check the quality of the service were leading to improvements in care for people.

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.

Staff had the skills to manage risks and meet people's needs. The service constantly reviewed staffing to ensure people's needs were met.

People felt safe and staff knew how to protect people from abuse. There were processes in place to listen to and address people's concerns.

Systems and procedures for supporting people with their medicines were followed, so people received their medicines as prescribed.

Good

Is the service effective?
The service was effective.

Staff received the support and training they required to provide them with the information they needed to carry out their roles.

Where a person lacked capacity there were correct processes in place so that decisions could be made in the person's best interests. The Deprivation of Liberty Safeguards (DoLS) were understood.

People's nutritional needs were met by staff who understood what support they needed.

People were supported to maintain good health and access health services.

Good

Is the service caring?
The service was caring.

Staff knew people well and treated them with kindness.

People's privacy and dignity was respected.

Good

Is the service responsive?
The service was not consistently responsive.

Whilst some people took part in meaningful activities, other people were not supported to follow their interests.

There were processes in place to deal with people's concerns or complaints but the service could not demonstrate there were measures in place to formally learn from feedback.

Requires improvement

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

The service was not able to demonstrate that effective audits were in place to drive improvement.

Requires improvement

Summary of findings

The provider and deputy manager were committed to implementing positive change but there was not sufficient time to measure the effectiveness of their proposals.

Clacton Family Trust

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 28 and 30 September 2015 and was unannounced.

The inspection team consisted of one inspector and two experts 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 experts by experience had experience of caring for people with disabilities.

We reviewed information we held about the provider, in particular notifications about incidents, accidents and safeguarding information. A notification is information about important events which the service is required to send us by law. We also looked at safeguarding concerns reported to us. This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect.

Our inspection focused on speaking with people who used the service, speaking with staff and observing how people were cared for. Some people had complex needs and were not able, or chose not to talk to us. We used observation as our main tool to gather evidence of people's experiences of the service. We visited the care home and the main supported living unit and met with people who used both parts of the service.

We spoke with 11 care staff. As the registered manager was not present when we visited, we met with the deputy manager, the provider and three care coordinators. We also spoke with 4 health and social care professionals about their view of the service. We made a further 2 telephone calls to families of people who used the service.

We reviewed a range of documents and records including care records for people who used the service, and those relating to the employment of staff, complaints, accidents and incidents and the management of the service.

Good

Is the service safe?

Our findings

A person told us, "I do feel safe here." Our observations of staff interactions with people demonstrated that people looked comfortable when staff approached them. A family member told us their relative knew who to speak to if they were concerned about anything.

Staff understood the importance of protecting people and keeping them safe. They were able to describe the different forms of abuse and were aware of what to do if they felt a person was not safe. Where people were assessed as being vulnerable there was guidance in place. Staff were able to describe how they might recognise possible abuse where people were not able to communicate verbally, for example through observing changes in behaviour or mood. We saw examples of where the service had been actively involved in raising safeguarding concerns and had attended meetings with relevant professionals. A health professional told us that they had, "Never had any concerns about [person's] safety, they are never neglected."

Staff knew how to manage risks to people's safety. For example, assessments were in place which identified where people needed pressure relieving cushions and mattresses to minimise the risk of pressure sores. A member of staff described how support and care plans had been altered following concerns regarding the risk to a person's mobility. We observed that rooms and communal areas were uncluttered, allowing people to access these areas safely. We saw that risk assessments which had been carried out to minimise the risk to people who used the leisure facilities at the care home such as the hot tub and sensory room.

Whilst accidents and incidents were monitored for individuals, these were not logged across the service to capture themes and minimise re-occurrence. The deputy manager told us that the provider was purchasing an IT system which would enable them to improve in this area. The new system would bring together individual information to assist in minimising risk throughout the service, for example through highlighting gaps in staff skills and knowledge which could be used to plan training.

There were enough members of staff in place to keep people safe, and staffing was being increased at the care home to better meet people's needs. We observed that where a person with complex needs had one-to-one staffing, that member of staff was not expected to care for other people. There had been a number of changes in the staffing arrangements within the service, in particular at the care home. Although we did not find that people were unsafe, the on-going disruption was causing anxiety, particularly to staff. Whilst we found there were enough staff at the service to keep people safe, staff told us there was a high turnover of staff at the care home and they were working long hours due to staffing shortages. In addition, staff told us there were not enough of them at the care home to provide personalised support to people, for example to take them out shopping.

We discussed this with the deputy manager who said that they had recognised there was an issue and had met with the provider and staff on the week prior to our inspection to discuss their concerns. As a result, the provider had agreed to increase the number of front line staff at the service, and we saw minutes of the meeting outlining this decision. In the week following our visit we were told that the new arrangement had been reviewed again and staffing numbers were increased still further. We were also told that the service was actively recruiting new staff to minimise the impact of long working hours on staff and the people they supported. We felt these actions demonstrated that that staffing was constantly under review and where there were concerns these were dealt with promptly.

Prior to our visit we received concerns that there was not enough staffing overnight. We were told by the deputy manager that staffing numbers had been determined following detailed assessments, involving social workers, community nursing and epilepsy nurses. We were shown records of these assessments. Where people had specific night time needs, staffing was in place to support them. In addition, a number of people had in place assistive technology to support them to stay safe. For example, a number of people with epilepsy had sensor pads, which meant staff were immediately alerted if they had a seizure overnight, and there were protocols in place to support people if this situation arouse. There was a member of staff in each bungalow and an additional support worker floating between bungalows plus additional staffing to meet specific people's one-to-one needs, as assessed. There was also a local manager on call, should an emergency arise. The deputy manager assured us that the current staffing in place overnight was meeting people's needs and that this was regularly under review where improvements were needed. For example, the shift

Good

Is the service safe?

patterns had been altered recently to improve communication between night and day staff by allowing a greater length of time between shifts for the handover of information. Night time staffing was constantly under review and the service had demonstrated that they were quick to adjust staffing where necessary.

The provider had a safe system in place for the recruitment and selection of staff. Staff recruited had the right skills and experience to work at the service. Staff told us that they had only started working at the service once all the relevant checks had been completed. We looked at recruitment files for three staff and saw that references and appropriate disclosure and barring (DBS) checks had been undertaken and the organisation's recruitment processes had been followed.

People received their medicines safely and as prescribed from appropriately trained staff. We observed medicines being administered and saw that staff were thorough and methodical. They took time and explained to people which medication was being administered. We saw staff records detailed medication training and staff told us that they only administered medicines after they had received this training. A health professional told us that when medicines were prescribed, staff followed instructions well. We looked at medicine administration record (MAR) charts and saw that these were easy to follow and up to date. Staff signed them when they had administered a person's medicine.

In cases where medicines were prescribed on an "as required" basis, staff followed personalised protocols, which were kept under review with their community nurse. We saw detailed guidance for a person where medication was available should they become distressed. We saw that staff had advice outlining a number of measures to be considered prior to administering medication, for example to support the person to spend time in the sensory room. People's medicine profiles highlighted any allergies they had. People had a updated list of their prescribed medicines, with photos showing the different medicines, which meant they could be easily identified and increased safety.

We saw that medicines were stored correctly and safely in a locked cabinet within a locked room. Medicine checks took place and additional training and supervision was provided where the managers identified further learning for staff. Staff were able to describe the arrangements for the disposal of medicines.

Good

Is the service effective?

Our findings

Our observations of staff interactions with people demonstrated that they were competent and confident in the care they were giving. A family member fed back in a recent questionnaire that, "If [relative] has any medical problems, I am advised of the situation and of the treatment being supplied." Another family member said staff had been effective in helping their relative develop their skills.

Training was prioritised within the service. The service provider had recently reviewed the effectiveness of their training programme and increasingly provided the training in-house, as they felt this meant it would be a better quality and more tailored to the needs of the people they supported. A member of staff told us that the quality of the training had improved following these changes. The manager had carried out direct observation as part of induction of new staff and gathered detailed advice to help develop their skills. A member of staff told us that they shadowed staff for one week in the bungalow they were to be based in as part of their induction.

We had received feedback before our visit that recently supervision had not taken place as regularly as before and saw this was reflected in some of the records we looked at, though we were not able to confirm this as the registered manager was not present. However, the staff members we spoke to told us that they were supported with supervision, which took place every three months.

The deputy manager and provider were aware that staff at the care home felt unsettled as a result of recent changes in staffing and management. They felt there had been a drop in morale which could impact on the support being provided and so were arranging to increase the support available to staff. For example, the provider had arranged for a human resources officer to visit the care home on a regular basis to provide drop-in sessions for staff.

People's capacity to make day-to-day decisions was taken into consideration when supporting them. The provider was meeting the requirements of the Deprivation of Liberty Safeguards

(DoLS). People who could not make decisions for themselves were protected. Appropriate DoLS referrals were in place, where required for people. Staff had a good understanding of Mental Capacity Act (MCA) 2005 and DoLS legislation and new guidance, to ensure that any restrictions on people's activities were lawful. Records and discussions with staff showed that they had received training in MCA and DoLS and they understood their responsibilities. Where restrictions had been put in place to keep people safe, for example where bed rails being used, there had been consultation with all interested parties acting in an individual's best interest.

External doors between the different houses and into the courtyard of the care home were locked, and could only be opened with a key fob. Although this was necessary to support some people to remain safe, this blanket approach meant more independent people had their freedom restricted. During our visit, the sun was shining however we observed that people did not make full use of the outside space and were unable to come out in and out of the garden area freely. However, we saw from discussion with people and staff and from individual records that the outside space was usually well used, in particular people spoke of how they enjoyed the hot tub. Within the supported living setting we found that people were less restricted as their property and any restrictions could be tailored to their individual needs.

We observed meal times at the care home and found that the atmosphere was pleasant and social. We observed that in one bungalow at the care home, staff offered people alternatives in line with personal preferences and meal times were flexible. In another bungalow staff cooked and served macaroni cheese, and people ate together. We observed that one person who didn't like the main meal on offer was offered a ham sandwich. Within the supported living setting people were supported to shop, prepare and eat meals of their choice. Staff at the care home told us however that people did not have real choice of what to eat as there was a laminated menu sheet which had been provided by managers and had to be adhered to. We were told that the menu on offer did not change to reflect the changing seasons and that people had not been involved in developing the menu. When we raised this with the deputy manager we were told that the menu had been discussed in the residents meetings, and that the menu sheets were for guidance and were not meant to be prescriptive. During our visit the deputy manager discussed this with staff to ensure they were clear on the purpose of the menu sheet.

Good

Is the service effective?

Staff were knowledgeable about people's specific needs when eating and drinking, for example, we observed someone being supported to drink with a straw and use a specialist bowl, as outlined in their care plan. Staff monitored people's weight monthly and put in place plans where people were at risk from poor nutrition. Where people needed food of a certain texture staff knew how to prepare meals to meet individual needs. Staff were able to describe who needed thickener in their drinks and why. We were also shown detailed care plans outlining how meals should be prepared. Staff gave us examples of other measures in place, such as controlling portion size, which supported people with specific nutritional needs arising from health conditions.

People's day to day health needs were being met and they had access to healthcare professionals according to their specific needs. For example, where necessary staff worked with the behavioural advisory team to fully understand the needs of the people within the service. Other people had detailed plans in relation to their health needs, such as epilepsy or diabetes. The involvement of health professionals was outlined in personalised health plans which were reviewed on a regular basis. We spoke to a health professional who supported a person with complex needs at the service and were told staff followed directions from health staff providing support.

Good

Is the service caring?

Our findings

We observed that staff had a kind attitude when supporting people. One person told us, “Staff are kind to me”, and described warmly the things they did together. One health professional told us the staff were, “Such a lovely bunch.” A family member fed back through a questionnaire that, “I rarely give notice of an intended visit but [person] always seems clean and happy.”

We observed that staff knew people well and spoke about them with affection. A member of staff told us that learning about people and their needs had been a key part of their induction, they said, “I was asked to read all the relevant care plans, and I was quizzed on them.” Staff cared about people and valued their achievements. One member of staff described how they had worked with a person to achieve an agreed outcome, which was to manage a task independently. They told us, “It took [person] months but they got there in the end!” It was clear that both the person and the member of staff had taken pride in this achievement.

A member of staff spoke with compassion about the need to work sensitively when offering choice and flexibility. So for example, in one bungalow we observed that people chose to have all their meals together despite being offered a more flexible arrangement . Staff told us that some people did not want to change from set routines which they had developed after years of living in a more structured setting and that change was offered gently and slowly over time.

We observed staff were skilled in communicating with people with specific communication needs, for example we saw staff signing with one person. We also saw that another member of staff had the skills, and patience to spend a great deal of time with a person when offering choice at meals.

However, information was not always presented in a way in which people could understand. For example, the menu sheets used by staff were not presented in alternative format, with pictures and so were not accessible to many people at the service. In one of the bungalows, there was a board to show which staff were on duty but this was not in use and there were no pictures used to support people who could not read.

We observed staff providing care and support respectfully and in ways that maintained people’s dignity. Staff had received training in supporting people with dignity and respect. We noted that staff were discreet when checking with people whether they needed any support with personal care such as using the bathroom.

Requires improvement

Is the service responsive?

Our findings

During our visit to the care home we observed that for considerable periods of time people sat in groups with one member of staff, watching pre-school programmes on a communal television. When we discussed this with staff they were able to tell us which person had picked the programme. It was not clear though whether the other people in the room had selected the programme and if it was meeting their needs. We felt that this did not demonstrate a personalised approach, particularly where people could not communicate verbally and were not able to leave the room without support.

When we raised this with the deputy manager, they arranged for us to meet with a newly appointed senior who had been given responsibility for improving activities within the care home. She showed us a new timetable of proposed activities and recently purchased materials which were ideal to meet the varied needs of people at the service. Whilst the choice of the new activities reflected the staff members detailed knowledge of people's needs. they had not involved people at the service in developing the timetable. Although we were assured that improvements were underway that the service had had not demonstrated that they consistently enabled people to engage in person-centred activities of their choice.

In the care home, we also observed some people engaged in activities of their choice, for example doing jigsaws with a carer. One person told us, "I like [worker], they help me with drawing and painting my nails." A family member told us that their relative could chose to go to the pub if they wanted to and in the evenings sat watching television until they wanted to go to bed. Another family member told us, 'Well, I can tell you they love living there. [Relative] talks to the manager and there are a few other carers he talks to." The service had a hot tub and a sensory room and staff described how the activity provided relaxation for the people they supported. We observed that in the supported living setting people received personalised care, for example we met a person going out shopping with a member of staff and were told that another person was attending a football match with their key worker.

People were assessed prior to starting at the service and people were invited for tea time visits before making the decision to move. People's care plans provided sufficient information which enabled staff to support people in ways they preferred. We noted that records for people were very personal. People's care needs were reviewed monthly or as needed, for example if they needed more support. We noted that staff had reviewed a person's needs following a distressing incident so that they could ensure they were continuing to meet their needs. Whilst the reviews had a focus on safety and capturing people's needs, they were pre-dominantly carried out by staff on behalf of service users. This was largely an office and paper based process and not all staff were pro-active in involving people in reviews of their service and planning of their care. Where staff had reviewed people's needs there was very limited use of pictures to aid communication and understanding.

The deputy manager told us that the service was committed to promoting greater person centred care. For example, staff had previously checked on people overnight every hour, irrespective of their needs. Following a review of care needs and staffing, this no longer took place and people were now supported in line with their needs, which reflected a more personalised approach.

Staff worked with people over time to achieve outcomes which were manageable, such as to learn how to use one piece of crockery independently. We observed that people were supported to develop skills and maintain their independence, for example we saw one person taking the rubbish out and another person was supported by a member of staff to do their laundry. We were given examples at the supported living service where people were enabled to make decisions about their life which reflected their personal choice.

The environment had been adapted to reflect personal choice. Rooms were decorated in line with people's preferences, and we were told by one person that they had picked the colour of their bedroom walls. In another bungalow there had been a vote to choose the colour of the communal area. We saw that referrals were in place to occupational therapists where adaptations were needed to meet people's needs, for example to a kitchen in the supported living service.

People were supported to keep in touch with their families and relatives told us they felt welcome to visit at any time. People's cultural needs were catered for and staff described how arrangements were in place for a person to maintain contact with representatives from their own religious faith. Other people who had specific cultural needs were supported to pursue their beliefs and interests.

Requires improvement

Is the service responsive?

The provider had a clear policy in place for responding to concerns and complaints. People knew who to speak to if they had concerns. A family member told us, “If [relative] had a problem, they would tell me and I would talk to the manager.” Where complaints were received they were logged and recorded and we saw examples of responses from the registered manager to families who had complained. The deputy manager gave us an example of where a complaint had been received and described the actions they had taken to resolve the concerns raised. The deputy manager was not able to show us clearly how information from complaints was used to improve the overall service. Within the supported living service there were no recent complaints but processes were in place to log complaints if these were received.

Requires improvement

Is the service well-led?

Our findings

Some people were very positive about the management of the service. A family member told us, "They are all very helpful…I can ring and talk to the manager anytime". A member of staff said they had worked elsewhere and had negative experiences, but that, "Here [supported living] it is different, it is organised and well run." However, whilst we were told that the supported living unit was being managed effectively, we received a number of concerns throughout the time of our inspection indicating that there were difficulties at the care home. In particular these related to poor management, communication, quality of care and staffing.

Whilst the deputy manager responded well to requests for information throughout our inspection, there was evidence that across the management team information was not always pro-actively shared with CQC and other professionals. Whilst one professional told us that the service had worked well with them over an issue which had arisen, we were informed of two other occasions when the service had failed to advise a professional of key information. The deputy manager told us that they rarely had to notify CQC of any accidents and safeguarding incidents, however during the time of our inspection we became aware of a significant safeguarding incident of which we had not been advised. We raised this with the deputy manager who immediately made the necessary notification.

The registered manager was not available on the day of our inspection and did not return to the service. However interim arrangements were in place for the management of the service until a new manager was in post. Staff at the care home told us that they felt unsettled by recent changes in management and staffing. They said they felt unsure about the support they would receive under new arrangements and about the quality of care at the service. Poor staff morale had an impact on the support provided and the general atmosphere at the care home. In contrast, we found good staff morale at the supported living unit. A member of staff told us that, "Any issues, we work together as a team to resolve."

We found that where staff were unclear when carrying out certain tasks this was often due to unclear communication and lack of clarity about roles and responsibilities. For example, some staff seemed unclear over who should communicate with outside professionals. When we discussed this with a member of staff supporting a person with complex needs, there appeared to be some confusion about who was responsible within the service for communicating with the health professional. There was not a specific member of staff overseeing a person's needs who would have responsibility for communicating with outside professionals. We were told by the deputy manager that the service had reviewed this and decided to set up a key worker system to help improve communication.

Whilst one member of staff at the supported living unit was positive and said that the service was open to listening to their concerns, some of the staff we spoke to at the care home felt that they had not been consulted about a number of changes which had taken place over the last year, such as how staffing was deployed within the service. We met with the provider who told us that they were aware that staff morale was poor and that they knew communication needed improving. They told us that they had already met with staff to discuss their concerns and monthly workshops were being arranged for staff to meet with human resource staff in order to, "Get away from management and build morale back up."

The provider and deputy manager demonstrated a commitment to improving the service, for example the provider was investing in a new computer system to improve the management of the service. They gave an example of where they would be able to use the new programme to help match individual workers to needs of people being supported. Whilst we were assured that the service was moving forward in a positive direction, it was too soon to measure whether the proposed improvements and changes were sustainable.

The service worked to resolve issues of poor practice and gave examples of where measures had been taken in response to concerns about staff performance. A member of staff also described how managers had responded when concerns were raised about poor manual handling practice and dealt effectively to resolve the issues.

The deputy manager explained to us that the culture at the service was changing to enable the people to receive a truly flexible and personalised service. For example, staff breaks were no longer taken at fixed times but were

Requires improvement

Is the service well-led?

arranged around people's needs and preferences. This process of change had been unsettling but the management team demonstrated that they were working with staff to resolve issues.

There was some evidence that people were consulted about decisions being made at the service. For example, service users were on the interview panel for selecting staff and applicants were observed interacting with people with complex needs to measure they suitability as carers. However, there appeared to be a culture where decisions about the service were led from above by the provider, management and staff. Measures to ensure people and their families had meaningful input into the development of the service seemed limited. This was particularly apparent in the care home where there had been such a swift pace of change, for example in how staffing were deployed.

We saw some evidence of audits taking place, however the service was not able to demonstrate they were measuring quality in a comprehensive way with a view to driving improvements. A questionnaire had been carried out with families within the last year, however we did not find any overall action plan to respond and resolve any concerns raised by the feedback. During our inspection we became aware of an action plan which had been put in place to resolve the current concerns, however it was too soon to be able to measure the effectiveness of the proposed changes.