Caretech Community Services (No 2) Limited

St Agnells House

Inspection report

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Date of inspection visit: 04 December 2014
Date of publication: 22/05/2015

Ratings

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

Overall summary

This unannounced inspection took place on 04 December 2014. At our last inspection on 01 August 2013 we found the service was meeting the requirements.

St Agnells House provides accommodation and personal care for up to 8 people with learning and physical disabilities.

There was not 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 and associated Regulations about how the service is run.

The Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict

Summary of findings

their freedom in some way, usually to protect themselves or others. At the time of the inspection there we identified that not all applications had been made to the local authority in relation to people who lived at the service.

The manager and staff were familiar with their role in relation to MCA and DoLS.

There were numbers of staff available to safely support people's needs however the use of agency staff meant care was not always consistent.

Incidents that required reporting to the Care Quality Commission had been made.

Peoples medicines were stored, managed and administered safely and staff had received appropriate training.

Staff were not clear on how to identify and report any concerns relating to a person's safety and welfare.

Staff were recruited through a robust procedure and were provided with regular professional development to ensure their knowledge was up to date.

Staff knew people well and provided support in a timely manner. There was sufficient food and drink available and people were assisted to eat and drink in a calm and sensitive way.

People had access to a range of health care professionals, such as chiropodist, mental health teams and a doctor.

People saw a doctor regularly and people were referred when there were concerns with their health.

There was not an effective system of regular auditing, review and action to ensure people received a quality service that kept them safe.

People's feedback including staff had been sought and acted upon.

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 were not always protected from abuse and avoidable harm by staff who knew how to report and deal with concerns.

There were sufficient staff available to meet people's needs however staff was not always consistent.

Effective recruitment practices were followed.

People's medicines were managed safely by staff who had been trained.

Is the service effective?

Requires Improvement

Staff told us they felt supported by the manager. Staff received regular training and development.

Staff had assessed people's capacity, however where an application to deprive a person of their liberty was required, this was not always completed.

Staff supported people at mealtimes in a kind and sensitive manner.

There was sufficient food and drink available for people.

Is the service caring?

Good

People were cared for in a sensitive, kind and caring manner.

People's dignity and privacy was promoted and people's independence was respected.

Is the service responsive?

Requires Improvement

Care plans and risk assessments had not been developed for all areas of identified need. We have made a recommendation to ensure records are accurately maintained.

People and their relatives involved in decisions about their care.

People felt they could approach the manager with any concerns or complaint.

There was a good provision of activities that promoted peoples individual hobbies and interests, however we have made a recommendation about this.

Is the service well-led?

Requires Improvement

There was not a registered manager in post.

Notifications that are required to be sent to the Care Quality Commission had been sent and incidents had been investigated.

Summary of findings

There was a lack of systems in place that audited and reviewed the quality of service provided.

St Agnells 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012 and to look at the overall quality of the service.

This inspection took place on 04 December 2014 and was unannounced. The inspection team consisted of one inspector and a specialist advisor who was an experienced nurse.

Before our inspection, we reviewed the information we held about the home, which included incident notifications they had sent us. We contacted the commissioners of the service and two healthcare professionals to obtain their views about the care provided in the home. We reviewed information we held about the service including statutory notifications and enquiries relating to the service. Statutory notifications include information about important events which the provider is required to send us.

During the visit, we spoke with three people who used the service to fully understand their experience of living at St Agnells. We also spoke with two relatives, four staff members, and the recently appointed manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

Staff we spoke with were aware of what constitutes abuse and the actions they should take if they suspected someone had been abused. The manager was aware of when to make an alert to the local authority safeguarding team. The provider had a policy relating to safeguarding adults at risk which detailed examples of the types of abuse and the signs which may indicate a person was being abused. Safeguarding matters were discussed both in staff meetings and in resident / relative meetings. For example, minutes from September 2014 demonstrated that relatives had raised concerns the previous manager had not involved them with safeguarding concerns. We saw the current manager had acted to speak with the local authority and ensure people would be invited in future where concerns were raised.

However, staff were not aware of the need to record incidents. We spoke with two staff members regarding bruising that had been noted to one person. They had made a note in the person's daily record, but not reported it as an incident. This meant that the manager was unaware of the unexplained bruise, and was unable to investigate further.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's and their relatives told us they felt safe at St Agnells. One person told us, "I like it here; the staff are nice to me and look after me when I need them to." One person's relative told us, "I don't ever need to think that [person] is not safe as the staff as so diligent and caring."

We looked at the recruitment information for two members of staff. A form detailing all of the checks undertaken prior to staff being employed was contained on the two staff files we looked at. Appropriate checks such as references, identification, criminal record and employment history were considered as part of the recruitment process. The provider's recruitment policy detailed the required pre-employment checks.

There were enough staff to keep people safe however care was not always consistently delivered to people. This was because there was a high use of agency staff who were not always aware of people's needs. Staff confirmed this however they did tell us that there were sufficient numbers to support people. The manager said that agency staff were being used when necessary to make sure there were enough staff on shift. However we observed one agency staff member repeatedly rush when assisting a person with drinking. We reported this to the manager who asked a staff member employed by St Agnells to assist who knew the person's needs better and supported them positively. The manager told us they would not use this agency carer in future. Overall, however, we observed that people's needs were met promptly, for example, one person was observed in the lounge to need support with their personal care needs and staff employed by St Agnells dealt with this promptly and sensitively. The manager said that agency staff were being used when necessary to make sure there were enough staff on shift and were in the process of recruiting additional permanent staff.

The manager told us they had reviewed the staff and their performance since arriving in post. As a result they were in the process of performance managing staff whose did not provide care as required by the manager. For example we saw documents that demonstrated staff had been performance managed for areas relating to delivering care. This meant that where staff provided care that was below an acceptable standard the manager took action to keep people safe.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks were assessed and staff were aware of how to support people in a safe way. There was evidence in people's support records that risks had been assessed. For example, one person had been referred for specialist support to reduce the risk of choking when eating. Staff had documented the recommendations and were aware of the risks people faced and how to reduce these risks. We saw there were also contingency plans set out in case of emergencies. These clearly identified what hazards were present for the person if they needed to leave the home in an emergency. For example people who used wheelchairs or who were unable to walk unaided.

Where people had been involved in an accident or incident, these were reported by staff to the manager who investigated the incident. We saw that the investigations

Requires Improvement

Is the service safe?

reached a conclusion of what had occurred and how the risks of a recurrence could be reduced. For example, one person had eaten a piece of plastic from a spoon. The manager had noted that plastic spoons were to no longer be used, and we saw this had happened during our inspection. This meant that the manager acted swiftly to investigate incidents to keep people safe.

Medicines were received, stored and disposed of securely. Controlled drugs were stored securely in a separate medicines cupboard. The amount of a controlled drug held in the cupboard matched the amount detailed in the controlled drugs register. We looked at people's Medicine Administration Records (MAR) and found that all medicines had been signed to indicate that they had been given.

Staff who administered medicines to people had attended the appropriate training and were assessed as being competent to manage medicines.

Requires Improvement

Is the service effective?

Our findings

Staff and the manager had received Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training. They demonstrated a good understanding and were able to explain how the requirements worked in practice. DoLS apply when people who lack capacity are restrained in their best interests to keep them safe. We found that people's capacity to make decisions had been properly assessed and they were supported to access independent advocacy services where necessary and appropriate. However DoLS applications had not been requested for all people who required one. For example, people who were unable to leave the building on their own without staff supervision. This meant that people may have been unlawfully deprived of their liberty. The manager told us they were in the process of assessing and referring people where required.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us they had enough to eat and drink. One person relative told us, "[Person] needs a lot of help and encouragement and the staff always respond and make sure they eat well." One person told us, "I like the food, and I like to help make it."

People were offered choices of food and drink and were able to assist with the preparation of their meal. Snacks were readily available in the home for people to help themselves to and the kitchen was accessible to people. Food records showed that different meals were provided to people, and people were supported by staff to plan their weekly menus. Meeting minutes which showed that people discussed food and drink choices and availability.

Where people had special dietary requirements such as diabetes, staff ensured a diabetic care plan had been developed and followed, which documented what the person was able to eat. Staff we spoke with were aware of people's dietary needs and supported people positively. For example one staff member was observed to gently stroke a person's cheek to attract their attention prior to offering them a drink. This ensured the person, who was at risk of choking was aware they were about to have something to eat or drink.

People and relatives told us they could access healthcare services when they required. People accessed a range of healthcare professionals such as GPs, nursing teams, speech and language therapists and chiropodists.

People and relatives we spoke with felt that staff were skilled and knowledgeable about their needs. One person told us, "The staff always help me when I need them to; they are very nice to me." A person's relative said, "The regular staff are great, sometimes the agency carers need a prompt, but overall they know how to care for [Person] and I am not worried."

Staff were supported to carry out their roles and told us the management team carried out regular supervision for them to discuss their development needs. Staff told us they were able to speak with the manager outside of supervision sessions if they had any concerns or needed advice. One staff member said, "I feel comfortable to seek advice or ideas from the manager as they always try to help us understand what the issue is and not tell us off."

Staff told us they had received training in a variety of topics relevant to their role. One staff member told us, "Training is non-stop; it seems there is always something new to learn." Training records showed that staff had undertaken a variety of training such as food safety, fire and safeguarding adults from abuse. Staff met with the manager to review their performance and development. Both the manager and staff member identified their key areas of strength and areas for improvement.

Good

Is the service caring?

Our findings

People and relatives told us staff were kind and compassionate. One person said, "I love [Staff member] she is lovely and friendly and I miss [staff member] when they are not here."

We saw that staff supported people in a kind, patient and respectful way. They clearly knew people they supported very well and had established positive and caring relationships with them. We observed a staff member supporting a person at the table with their arts and crafts. The staff member listened attentively to the person and did not interrupt, and made helpful suggestions when required. We later saw one staff member offer support when they had become upset and low in mood. The staff member took the time necessary and offered reassurance and encouragement until the person's mood lightened. We saw later in the day their mood had significantly improved and they returned to the group for lunch.

When staff assisted people they gave explanations in a way that people were able to understand, such as pointing, gesturing or speaking clearly to offer people a variety of options. For example staff were aware of how to use Makaton which is a type of sign language.

People's privacy was maintained. We observed that staff knocked and waited for a response before entering people's rooms. When staff supported people with their personal care, they did this in a manner which protected their dignity. For example we saw one person who required assistance with their toileting needs. The staff member approached them quietly; spoke to them softly and gently led them away to support them. When staff addressed people we heard they did so using people's preferred names.

An advocacy service was available for people to use if they wished to; however at the time of the inspection nobody was using an advocate.

Staff involved people in decisions about the support they received. One relative told us, "They don't take things for granted, but they talk to me, not just about [Person] but about anything in the home." We observed throughout the inspection that staff discussed with people their options around their support needs. There were regular house meetings where people could talk about issues relating to the service. For example we saw discussions had taken place around activities and developing a new method of care planning.

People's support records contained information regarding their preferences such as what they preferred to be called, the types of activities they enjoyed and their food likes and dislikes. Staff were aware of people's preferences. For example, staff were aware of the food one person disliked and the activities another person enjoyed.

Requires Improvement

Is the service responsive?

Our findings

We saw that promoting choice and independence were key factors in how care and support was planned and delivered. Care plans and associated documentation had also been written in an easy read format to assist people when discussing their care needs. Where people had special dietary requirements such as diabetes, staff ensured a diabetic care plan had been developed and followed, which documented what the person was able to eat. However we noted that where food and fluid was required to be documented this had not always happened. In one example we saw staff had documented a fluid as having been drunk even though the person had refused most of the drink. This can be misleading when reviewed as it will suggest to a healthcare professional that a person was drinking more than they actually were. This may leave people at risk of dehydration, urinary tract infections or degeneration of skin tissue viability. We recommend that the records relating to people's nutritional needs kept accurate and documented when meals or drinks are given.

People had been fully involved in discussions about how their care was assessed, planned and delivered. Care plans, goals and aspirations were reviewed during regular meetings with designated key workers to ensure they accurately reflected people's needs. They were personalised and contained detailed information about people's background, personality and preferences. They included clear guidance about how people wanted to lead their lives and the support they needed.

When people first moved to St Agnells, staff carried out a comprehensive assessment of their needs. This was completed with input from the person and their relatives, and focused on health needs as well as social needs, such as education, activities and personal preferences. We saw throughout the inspection that people's preferences were considered. For example, one person decided they did not want to get up at their usual time, so staff acknowledged this and returned later.

People told us that staff supported and respected their independence. One person said, "[Staff] help me with cooking and washing and things like that and they helped me decorate my room in my favourite colour." A social care professional we spoke with told us, "They are all fully involved in their care and asked how they like the home to run, and the staff are really good at getting people to do things for themselves where they can."

People had participated in activities and work which they had chosen and that was individual to their personal needs. One person's relative commented, "There is always something going on, the staff mix it up a bit. Like tonight everyone is helping to make food for the Christmas party." There was a range of group and individual activities that had been provided to people. We observed on the day that staff were supporting people with one to one activities such as listening to music, and films, and a second person was being supported with their arts and crafts. People appeared very content in the activity they were engaged with, and staff took the necessary time to ensure they gave each person dedicated time. One person proudly showed us a range of drawings and collages that they had displayed on the walls in the communal areas. However, at the time of our inspection people were not attending events or activities in the community such as pre-arranged day service trips or pub lunches. For example, on the day of our inspection one person was scheduled to attend the pub for lunch, which was a weekly planned activity. Due to issues with transport this person did not go as planned. We saw that they were unsettled and disturbed by this. We recommend that the provider considers alternative methods of transportation for people when the original method is not available.

People were encouraged to raise any concerns, or problems they had with their key workers or during regular house meetings. Minutes of meetings demonstrated that people's concerns had been discussed openly and transparently. For example, the departure of the previous manager had been reviewed in the meeting along with a discussion about keeping safe. People were also encouraged to raise complaints with the manager about any concerns they wanted to discuss outside of this meeting. There was clear guidance available for people to report their concerns, and the contact details for the Local authority and Care Quality Commission were available. One person we spoke with told us if they were not happy with anything they would ask their key worker to help them make a complaint to the manager.

Requires Improvement

Is the service well-led?

Our findings

We saw that a system of audits, surveys and reviews were used to good effect in obtaining feedback, monitoring performance, and managing risks to keep people safe. These included areas such as infection control, medicines, staffing and care records. We saw that where areas for improvement had been identified action plans were developed which clearly set out the steps that would be taken to address the issues raised.

However, some key audits we asked for were not submitted to us as requested. For example we asked to see a provider's quality audit and actions from this; however this was not received, along with a number of other key documents. As such the manager could not assure us that they had fully assessed the quality of the service provided as a range of audits had not been completed.

When we visited, the service did not have a registered manager in post. The manager told us they had been managing the home for around six months. Our records showed that they had submitted an application to CQC to become the registered manager at the location which was progressing. The location had been without a registered manager since July 2014.

People, their relatives, staff and care professionals were all positive about the manager and the way the home was now run. One person commented, "Things have really changed for the better over the past few months, this new manager has really embraced the home and listened to what needed to change." One staff member told us, "Both the manager and deputy are always there and listen to us if we think something needs to be changed or improved." We saw a document titled 'Risk register' that the manager had developed which recorded each concern that staff had raised. Each concern or issue was prioritised and regularly reviewed.

The new manager had incorporated a set of visions and culture within the home that reflected individual choice, helping people be independent and having an open and transparent culture. When we spoke with staff we could see this ethos was clearly understood and demonstrated. One staff member told us, "There have been a lot of changes, part of the reason we have agency now is because people left as they didn't like the new management style. It's about the people though at the end of the day, and if things improve then it's all good."

The manager told us about the plans for the service and what they had assessed as being the main areas requiring development. For example, they had identified that people's support records were not as personalised as they needed to be and were in the process of addressing this.

People who lived at the home, relatives and staff had been involved in developing and improving the home. Minutes of meetings we saw demonstrated that a new approach to care planning had been discussed, as well as activities and social events.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation (9) (1) (a) (b) (I) (ii)** **When agency staff supported people with their care needs they did not do so in a manner that met their needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **Staff were not aware of areas of suspected abuse that required reporting.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **Where people required a DoLS authorisation to be sought this had not always happened.**

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.