Response Organisation

A G Palmer 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?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We inspected AG Palmer House on 22 June 2015. The inspection consisted of four visits in total between the 22 June and 3 July 2015. AG Palmer House provides personal care to people living in their own homes in Oxfordshire. The service also provides personal care to people who are receiving a service from the provider's supported housing projects. The majority of people who receive a service have mental health needs.

At our last inspection in September 2013 we required the service to make improvement with regard to the care and welfare of people who used the service. We found that there was no information about how risks were managed or what steps were being taken to reduce the risk to the people using the service. The provider sent us an action plan in December 2013 stating the action they would take to improve the service to the desired standard. At this inspection in June 2015, we found that these improvements had not been made.

There was a registered manager in post at the time 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

Summary of findings

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.

People had risk assessments in place that documented risks in relation to their needs. However, these risk assessments still did not always document strategies staff should take to mitigate these risks. On one occasion staff had been unable to provide care because they were un-prepared to manage risks.

We reviewed care files of people who lived in their own homes as well as people who were supported within a project setting. We observed there to be a noticeable difference in quality between the two. People living in their own homes had clearer more organised care plans in place. However the areas of improvement we found applied to all people using the service.

There were enough suitably qualified and skilled staff to ensure care was provided to people, however staff were not always deployed in a way that met people's needs or supported their well-being.

Staff we spoke with had a good understanding of safeguarding, what constituted abuse and what action they would take if they suspected abuse. However the service was not always following the procedure set by the local safeguarding authority.

The service had an awareness of the Mental Capacity Act (MCA) 2005. The MCA is the legal frame for ensuring people right to make their own informed choices is respected. However we found the organisations systems were not supporting this understanding through their records. We have recommended that the service familiarise themselves with the MCA code of practice to improve this area.

The service had a system in place to support staff through formal supervision meetings and appraisals. However this system was not being used effectively and many staff were not receiving this support as a result. Staff told us they felt they were supported but would benefit from more formal meetings to discuss progress and plan their development.

People's planned care was not always person centred. People's records did not reflect their involvement or the involvement of other relevant people. Care was not clearly designed around the person's wishes and preferences.

The service had systems in place to monitor the quality and safety of the service but they were not effective. Intended audits were not recoded to evidence improvement of the service. Spot checks that were designed to monitor the direct quality and safety of service delivery were also not being carried out consistently. There was also no local system to monitor accidents and incidents that occurred within the service to support the organisation in learning from these events.

Some staff were described as caring. Relatives provided lots of positive feedback with regard to more experienced or regular staff who were described as, "excellent" and "like angels", but these views were not shared by everyone in relation to staff generally. We were told of some staff who were rushed or brusque in their approach which impacted on peoples well-being.

We were told of a recent review of the service that had identified some of the concerns we had found and action was being taken to try and improve the areas of concern however, this action had not been taken at the time of our inspection and not all of the issues we had identified had been identified in this review.

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We identified six breaches of the Health and Social Care Act 2008 (Regulated Activity) Regulation 2014. You can see what action we have required the provider to take at the end of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

Risks associated with people's needs were documented in a way that meant staff could not meet people's needs safely.

Staff were not always deployed in a way that met people's needs and staff levels meant that senior staff could not always fulfil their responsibilities.

People were not always protected from the risk of abuse as staff understood their responsibilities in relation to safeguarding but the correct procedure was not always being followed.

People's medicines were managed safely and in line with their documented needs. Staff who were supporting people to take their medicines were trained and competent to do so.

Is the service effective?

Requires improvement

The service was not always effective.

People's decision making was not always supported by an adherence to the Mental Capacity Act (2005).

Staff felt supported but did not receive regular supervision and appraisal. Some staff we spoke with felt this was important to them in caring out their role effectively.

Is the service caring?

Requires improvement

The service was not always caring.

Most staff were described as caring but some relatives felt there were some staff whose approach did not reflect a caring attitude which impacted on people's well-being.

Some relatives talked about the positive relationship people had with more regular staff.

Is the service responsive?

Requires improvement

The service was not always responsive.

Peoples care and treatment was not designed in a way that reflected their needs and preferences and that centred around them as an individual.

Complaints and concerns were not always managed appropriately. A number of relatives told us they had not received a response to their complaints and we found complaints were not always recorded?

Summary of findings

When most people's needs changed the service responded and accessed the appropriate professional support. However there were occasions where recommendations were not updated into people's care plans and staff we spoke with felt the documented care did not always reflect people changing needs.

Is the service well-led?

Requires improvement 

The service was not always well led.

The service had a system in place to monitor the quality and safety of the service but this was not always effective. Audits were not carried out consistently to evidence areas of improvement. Spot checks were not conducted consistently.

Some relatives and staff spoke highly of the leadership but others felt that communication needed improvement and that their concerns were not always taken seriously.

There was not a clear vision for the service. Staff we spoke with were unable to speak with us about the service vision.

A G Palmer 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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place across four visits between the 22 June and 3 July 2015 and was unannounced. The inspection team consisted of three inspectors and two experts by experience. An expert by experience is somebody who has experience of using this type of service.

At the time of the inspection there were 79 people receiving a service at this location, 71 of whom lived in their own homes and eight of which were supported within the supported housing arm of the organisation. We reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law.

We spoke with three people and 18 people's relatives. We also spoke with 11 care staff, two senior carers, one regional manager, one director, the registered manager and Oxfordshire safeguarding team.

We looked at 17 people's support plans, 11 staff files and records relating to medicines and the day to day management of the home.

Requires improvement

Is the service safe?

Our findings

At our last inspection we required the service to take action in relation to a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found that risks in relation to people's needs were not always documented or provided guidelines with how to manage the risk. At this inspection we found that the required improvements had not been made.

People had risk assessments in place that documented risks, but there was not always guidelines in place for action staff must take to mitigate these risks. For example, one person was known to display significant behaviours that may present as challenging. There was no strategy in place for staff to manage or mitigate these risks. We were told by some staff there had been occasion where some staff had left the house without providing the care due to not expecting the level of challenge they experienced. We also saw a number of people who were at risk of falls and others at risk of pressure sores. In each of these risk assessments there were no guidelines or 'remedial actions' in place to ensure risks were managed. We spoke with senior staff and the manager about this issue and we were told that these guidelines should be in place. They also told us that they couldn't be certain in the absence of these guidelines that all staff, especially new or 'junior' staff would know how to meet these people's needs. People's relatives also confirmed that there had been occasions where some staff didn't appear to be aware or have the necessary experience to provide the planned support adequately. One relative commented, "Some have been excellent, can't fault them, but others clearly need more information or guidance, they don't seem to really know what to do".

These issues were a continued breach of regulation 9 of the Health and Social Care Act 2008

(Regulated Activities) Regulations (2010) that now corresponds to Regulation 12 of the HSC 2008 (Regulated Activities) Regulations 2014.

People were not always safe from the risk of abuse. Staff we spoke with had a good understanding of safeguarding and what to do if they suspected abuse. However, we saw a number of incidents had been referred to social workers but were not always known to the local authority safeguarding team in line with the service policy and the correct procedure. For example, a concern had been raised with regard to one person and their safety and wellbeing around a relative. There was no indication as to the outcome of this concern and the local authority safeguarding team had not been informed about it. We spoke to the manager about this who confirmed the issue had been discussed with commissioners but not referred to the safeguarding team.

These issues were a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

We also found that there was not a system in place to monitor incidents and accidents. We noted a number of incidents such as falls that had not been logged. We raised this with a senior member of staff responsible for managing these reports who showed us there was only one on record that did not effectively demonstrate that appropriate action was taken. We were shown a robust cooperate system in place to manage and act on incidents and accidents, however the information required was not always being reported into this system. We spoke to the senior member of staff responsible for this system who told us, "I can only log what is reported to me".

These issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

There were sufficient numbers of staff. However, staff were not always deployed in a way that met people's needs or supported their wellbeing. Relatives we spoke with told us the organisation of staffing sometimes left them anxious and worried for their relatives as this impacted on their wellbeing. Comments included, "We just don't know who is coming at times and they can often not be here when you expect them", "My relative becomes very anxious, it's got much worse, the regular care just doesn't really happen" and "They don't realise if they are late my relative misses out on all of his plans and that's all he has to look forward to". Staff also confirmed this was a problem. Comments included, "Things are just very disorganised, things are changed and we don't know why. You can end up working silly hours, it's chaos at times" and "It's not the number of us, it's the way we're organised, it could definitely improve, it effects the people we support at the end of the day".

Requires improvement

Is the service safe?

These issues were a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014)

People received their medicines as prescribed. Medicine Administration Record (MAR) sheets accurately recorded when people had their medicine. Medicines were securely stored in people's rooms. When medicine errors were identified or gaps were found on MAR sheets the service took appropriate action. For example, where staff had not completed the records correctly, additional assessments were done to ensure that staff competency improved.

The service followed safe recruitment practices. We looked at five staff files that included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Records were also seen which confirmed that staff members were entitled to work in the UK.

Requires improvement

Is the service effective?

Our findings

Most staff we spoke with felt supported, however not all staff received regular supervision. In each staff file we reviewed it was not always clear what support staff received and how they benefited from this support in order to improve their practice. Not all staff had appraisals recorded on their files to show how their progress was being discussed and there were no clear development plans for them to develop professionally. However, some staff did feel they had opportunities to develop professionally. We discussed these issues with the registered manager who was aware of the issue and had planned to take the supervision of staff back on and developed a new tool in order to better identify the stresses amongst the staff team. This had been started but was not fully operational at the time of our inspection.

People were not always supported by suitably qualified and skilled staff. Relatives we spoke with highlighted the difference in suitability of the staff and their skills. Comments included, "They used the hoist, but at first they didn't know how to work it", "The experienced staff seem more competent, perhaps the newer staff need more training" and "Some staff are excellent, but others are to brusque". Staff spoke highly of their training opportunities. Comments included; "We get enough training, it's something the manager is clear on" and "Training is always available, it's just having the time to get to it". However, we were told by a number of staff that new staff did not get enough support before starting on their own. Comments included, "The newer staff need more time really, it can be quite rushed" and "I felt I could have been shown more, I felt a bit in at the deep end". Relative's comments supported these comments. One relative told us, "The new staff don't always seem that confident, I know my relative gets nervous" and "Some new staff we have asked not to have back".

These issues are a breach of regulation 18 of the Health and Social Care Act 2008 (regulated activities) regulation 2014.

We discussed training more widely with the manager who explained that all staff were being put on the care certificate. The manager felt that training within the organisation, despite challenges, had changed recently more in line with her own vision and preferred approach regarding best practice. Staff felt that they had opportunities to develop professionally and access professional qualifications.

Most staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA). The MCA is the legal framework to ensure people's legal right to make their own decisions was being adhered to. However, some staff were not so clear and the documentation recorded in people's files did not always reflect an understanding of the key principles of the act. For example, we observed a number of files where there were generic references to MCA which did not identify specific decisions for people at a specific time. We found no actual assessments of people's capacity within their care files in relation to any decisions.

People had access to appropriate health professionals as and when required. People were supported to attend GP appointments and visits to the dentists. The service also accessed support of other professionals such as speech and language (SALT) and district nurses when required.

We recommend that the service familiarise themselves with the MCA Code of Practice 2005.

Requires improvement

Is the service caring?

Our findings

Most people and their relative described the staff as caring. Comments included, “They [the staff] are very caring, can’t fault them” and “Very caring, my relatives life would be so much worse without them”. However, we spoke to some relatives who didn’t agree. Other relative felt that whilst some of the carers were “fantastic” others did not always display a caring approach. Comments included, “They [the staff] will wait outside for as long as possible, come in and rush out”, “Some of them need more training they don’t show any concern toward my relatives illness” and “The care could be better and more consistent”.

We saw no mention of advocacy in people’s care files. Advocacy is a process of supporting and enabling people to express their views and concerns and promote their rights and responsibilities. We saw some people did not have support of relatives or next of kin who would benefit from the opportunity to receive advocacy support.

Most relatives we spoke with told us that there were very positive relationships with more regular staff but regular staff were not always available. Comments included, “When the regular staff are possible the relationships are great, but unfortunately it changes quite a bit” and “My relative enjoys the company of the more regular carers, but it’s a shame they can’t always stick to the same people, it makes making relationships hard”.

Relatives we spoke with told us that staff were good at promoting independence and involving people in the day to day decisions in relation to their care. Comments included, “The care staff are good at making sure my relative knows what is happening and check if they need anything else” and “Our biggest hope was that where things could be done for themselves this would be encouraged and it is”.

People and their relatives also told us that care staff respected privacy and dignity. Comments included, “the experienced carers are very good, very discreet and respectful” and “the carers are very careful to ensure people’s privacy”. We also observed staff being mindful of people privacy during our inspection, knocking on their doors before entering and making sure people are happy to speak with us before we arrived.

We recommend the service considers how to tell people about advocacy services and support people to access these services.

Requires improvement

Is the service responsive?

Our findings

People's support plans were not personalised. We found each person had a generic template with standard phrases rather than personalised information showing what each individual wanted. For example, in people's support plans there was a section for 'goals' in each aspect of their care. These goals only contained generic statements such as 'to improve well-being', but did not say how, or what this person wanted to achieve. We also found that in some people's records the names throughout the document changed. We were told that this was where the same templates were often used and the names were not always changed properly.

People and their relatives were involved in the initial assessments when entering the service, but there was no evidence this person centred approach carried on throughout the review of people's care. Relatives we spoke with told us, "We had a meeting at the start, I couldn't tell you what's been happening since though, it would be good to be included" and "I don't get asked about anything and I am the main point of contact". We also found that recommendations made by professionals were not always updated into people's support plans.

People's views and preferences were not reflected in support plans. We were unable to understand much about each person because there was no detail of information regarding who the person was or about their personal histories. Staff we spoke with told us they would benefit from more information about the people they supported. Comments included, "The paperwork doesn't really tell you much to be honest", "You don't really know what to expect until you meet the person" and "We are getting more person centred it used to be much worse". We were informed by one person's relative that their relative could on occasion miss planned activities due to the care not being at the agreed time or around their wishes".

We raised these concerns with a senior manager who had a good knowledge of each person the service supported and recounted a number of meaningful stories in relation to people, but acknowledged this information was not captured in a way that supported the design of people's plans.

These issues were a breach of regulation 9 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives knew how to raise concerns with the service. However, not everyone was confident action would be taken. We saw the service had a complaints policy to manage complaints received. However we found no record of any compliant in the service records. The regional manager told us this was possibly due to issues being managed well before they reached the formal complaint stage. A number of relatives told us they had raised complaints that ranged between slight concerns to serious issues. Relatives told us they do not hear back and were very unhappy. Comments included, "I have raised a number of things, you are told it is in hand then you don't hear anything" and "I am not sure who to go to with an issue to be honest, I mention things to staff but nothing changes" and "I've stopped bothering you don't hear anything back".

These issues were a breach of regulation 16 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

We did identify people who benefited from staff who were responsive to their needs. For example were saw that one person whose mobility had deteriorated this was raised and appropriate assessments were done to ensure this person was supported effectively. We also identified people who were referred to GP's when their health was identified as being unusual, or where people were 'not being themselves'.

Requires improvement

Is the service well-led?

Our findings

The service had recently conducted a review of the service that had identified a number of additional resources needed to improve the quality and safety within the service. There was a plan in place to recruit a new deputy manager to ensure the manger could remain more connected to the care being delivered but also have the time to ensure systems in place to monitor quality and safety were effective and used consistently. However, these changed were not yet in place at the time of our inspection.

There was a system in place to 'spot check' care being delivered in the community along with competency checks regarding medicines. We saw that these had started to happen more regularly but were not happening consistently. Staff we spoke with had not yet had a spot check or knew if there was a plan to have one. There was no formal system in place to monitor the quality of care files for people who used the service. The registered manager told us they did audit files but did not record their findings. Neither of these approaches had identified the issues we identified at this inspection and there was no action plan to improve the service based on these systems.

We observed a number of inaccuracies in care files we reviewed which had not been identified by these audits. For example, the section of peoples risk assessments designed to highlight whether a person required support due to mental capacity was consistently ticked as yes in each record we reviewed. We raised this with the regional manager who agreed the section had been misinterpreted. We also found a number of care files hard to navigate due to inconsistencies in layout and up to date information not always being easy to identify.

We found that the service did not routinely respond or improve the service as a result of feedback. We saw that the service carried out a satisfaction survey in November 2014 to gather the views of people and their relatives. This survey showed that the satisfaction of the service had risen since the last survey. We were sent the findings of the most recent survey which was dated June 2015 and not all of the identified issues had been acted upon. There were a number of issues with regard to people being unhappy with the support they received as well as the punctuality of their carers. No action had been taken as a result of these findings. Since the inspection we have been sent information that shows the service have made contact with stakeholders of the service in relation to lateness that may be caused by road works in the local area.

These issues are a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed the vision of the service with the regional manager and director which focussed on providing excellent support to people and providing opportunities for increased independence and wellbeing. This was to be provided by staff who were well trained and supported. However, staff within the service were not able to speak with us about the vision. Comments included, "I'm not sure on the overall visions, but I am just here for these guys" and "It's a bit confusing, I do homecare really and not the day to day stuff". Some of these comments matched our observations that despite the providers overall vision, the specific vision for this service was not completely clear. This issue was also highlighted within the service's statement of purpose which was not unique to this service and also policy documents we had been shown were shared with other services that didn't always identify this specific service. We raised this with the regional manager who told us they agreed there needed to be more of a physical separation between services and had already looked at properties to move the service to.

Some relatives were complimentary of the leadership. Comments included, "I find the manager very helpful" and "The managers always seem approachable and happy to help". However, these views were not shared by everyone we spoke with. Other relatives felt that whilst managers were appropriate they we not always reliable. Comments included, "For me the issue isn't with the carers it's with the leadership, things just don't get better despite raising issues" and "Things just feel disorganised and that is down to the leadership I think". Whilst some of these statements matched our observations, we did observe many of these issues had been identified by the provider and there were plans in place to improve the clarity and quality within the service.

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 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users must be appropriate, meet their needs, and reflect their preferences. This must be done by carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user and designing care or treatment with a view to achieving service users' preferences and ensuring their needs are met. Service users must be enabled and supported to understand the care or treatment choices available to the them and to discuss, with a competent health care professional or other competent person, the balance of risks and benefits involved in any particular course of treatment. Service users must be able to make, or participate in making, decisions relating to their care or treatment to the maximum extent possible. Regulation (9) (1) (a) (b) (c) (3) (a) (b) (c) (d)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation. The registered person must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. Regulation (16) (1)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 1. Service users must be protected from abuse and improper treatment in accordance with this regulation. Systems and processes must be established and operated effectively to prevent abuse of service users. Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. Regulation (13) (1) (2) (3)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet people needs' Persons employed by the service must receive such appropriate support, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation (18) (1) (2) (a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation (12) (1) (2) (a) (b) Care and treatment must be provided in a safe way for service users. Assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks.

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); These systems must assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Services must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided and evaluate and improve their practice in respect of the systems in place. Regulation 17 (17) (1) (2) (a) (b) (c) (f)

The enforcement action we took:
Warning notice