Orwell Housing Association Limited

Kittens Lane

Inspection report

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Ratings

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

Overall summary

We inspected Kittens Lane on 16 and 17 October 2014. This was an unannounced inspection and was completed over two days by one inspector.

Kittens Lane provides a home and care for up to 10 people with a learning disability and complex needs. It is divided into two self-contained bungalows, one for six people and one for four.

There is 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.

People were protected from abuse. Staffing levels met people's needs and staff were able to respond to people promptly. Recruitment processes were robust, so contributing to safeguarding people. However, there were some aspects of the service people received which were

Summary of findings

not safe. Risks to people's safety associated with activities were not consistently identified, assessed and managed. Some medicines were not properly checked to ensure they were managed safely.

The premises were maintained safely, including emergency systems used in the event of a fire. We have made a recommendation about the home's guidance for evacuating people safely.

Staff were well trained and understood how to support people with their personal and health care. People had access to healthcare professionals and staff sought medical advice promptly on behalf of people if they became unwell. Staff understood the requirements of the Mental Capacity Act (2005) and the importance of people being supported to make informed choices. The manager was aware of the Deprivation of Liberty Safeguards. This meant they were working within the law to support people who might lack capacity to make their own decisions.

Staff were caring and compassionate and treated people with respect. They offered people comfort and reassurance.

People's independence was encouraged as far as practicable and we saw that they were supported to access activities within the community. However, staff did not have access to individual plans of care showing people's needs were regularly assessed and reviewed or which reflected their individual preferences.

Quality monitoring systems were insufficiently robust. Systems had not identified issues with maintenance of records, the way risks were assessed and managed, or that the provider's guidance for supporting staff was not being adhered to. Half of the eight staff spoken with felt well supported but the remainder and some relatives were concerned about staff morale and how this might affect care in the long term. We have made a recommendation about motivating staff and team building.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. Some aspects of medicines management were safe but others could not be properly audited to ensure people's safety. Risks to people were not properly identified, assessed and managed.

Recruitment processes were robust and there were enough staff on duty to support people safely. Staff were aware of the importance of reporting abuse. Checks were made to ensure the safety of the premises. We have made a recommendation about plans for evacuating people from the service in an emergency.

Is the service effective?

Good

The service was effective. Staff were competent to meet people's needs. Staff supported people to get maintain their health and to eat and drink enough.

The Care Quality Commission monitors the Deprivation of Liberty Safeguards. The service complied with these and the manager was aware of people's rights.

Is the service caring?

Good

The service was caring. Staff were kind and compassionate. People's rights to privacy and dignity were upheld. Staff spoke with people respectfully and ensured confidentiality was promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Staff supported people with activities in and outside of the home. However, staff did not have access to supporting information about each person to ensure the care they delivered was personalised to each individual.

There was a process for dealing with formal complaints but some people's representatives did not feel that less formal concerns about aspects of people's care were responded to.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led. Quality monitoring systems had not identified that staff were not supported through supervision in line with the provider's expectations. They had also not identified shortfalls in records relating to care and the management of risks to people.

Staff and relatives were not all confident the service was managed in a way that was open, inclusive and receptive to their views.

Kittens Lane

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 16 and 17 October 2014. The first inspection day was unannounced. The inspection was carried out by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed this information when we were preparing for the inspection. We also checked our records for the provider's monthly quality monitoring visits and for any relevant notifications.

To gather further information, we contacted the GP providing support to people living at Kittens Lane. We also contacted a speech and language therapist and community learning disabilities nurse who were providing support and advice.

During our inspection we spoke with four people who use the service but their communication skills and cognitive abilities meant they were not able to tell us in detail what they thought. We asked six relatives of people living in the home for their views. We spoke with eight staff members and the registered manager. We looked at the available records relating to care for five people using the service and reviewed staff recruitment records for two staff employed within the last year. We looked at the supervision checklist, duty rosters, training records and records associated with the safety and maintenance of the home.

Requires Improvement

Is the service safe?

Our findings

Three long standing staff members told us about an activity the manager had organised. They said that, from their knowledge of the person and their behaviour, they considered the activity was not wholly suitable and presented risks to the person's safety. A staff member and relative told us how they needed to intervene to prevent the person harming themselves and others because they had become very agitated. The person's relative said, "New staff are unaware of the profound difficulties involved, or what's been tried before and what might happen." We checked the person's records and found that there was nothing to show that risks had been assessed before the outing took place. This meant that action had not been taken to ensure it would be safe for the person to engage in the activity.

Staff told us that they had concerns about the lack of guidance available to them about managing risks for people while they were being supported. We found a note in one person's folders indicating that risk assessments were being updated and retyped and had been removed in May 2014. This meant there was no underpinning guidance for almost five months to show staff how they should support that person safely.

We noted that balances of medicines not supplied in the 'monitored dosage system' were not always recorded if any of these were carried over from the previous month's supply. This meant that medicine administration records (MAR) did not properly show the amounts of these medicines that were supposed to be available within the service at any one time. For example, one person's MAR chart recorded only that 'part' of their supply of medicine had been carried over at the beginning of the month but not the actual amount. We found that four doses had been supplied to the person's family for a home visit, 24 had been given and that the packet originally contained 28. There were 12 sachets remaining when there should have been four. This meant that there was no way checking and auditing that people received these medicines as intended and that they were accounted for.

These concerns demonstrated a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not able to tell us whether they felt their medicines were managed safely. However, we concluded that most medicines were managed in a way that promoted people's safety. Staff told us that they had training in the management of medicines and were able to tell us what checks they made when they were giving medicines to people. They said that their competency to administer medicines was assessed from time to time, to make sure they were able to do this safely. We noted that staff kept the keys for medicines either in their possession or in a safe. We concluded that people's medicines were stored safely.

There was clear guidance displayed on the medicine cabinets about the expiry dates for preparations such as eye drops, inhalers, and creams. We found that these items were clearly labelled with the dates that they were opened and when they should be disposed of. None were in use which were past their expiry date. This meant that people could be assured these medicines remained safe and effective to use.

Relatives told us that they felt staff protected people from harm and abuse in the home. One said, "Definitely they do." They went on to say that if they had any concerns they were confident these would be dealt with and that they could, "…go up the next tier…" if they felt further investigation was needed. Staff told us that they had training to enable them protect people from abuse. They were able to tell us about the signs they would look for, including any changes in someone's behaviour, which might present a concern that someone was being abused. They were clear about the need to report any such concerns to the management team. We found guidance within the file for team meeting minutes showing how staff had also been advised they could report any concerns to the local authority safeguarding team if they suspected someone was being abused. This contributed to ensuring people were protected from abuse.

We were aware of one concern which had not been recognised as potential abuse and reported to the local safeguarding team promptly. There was a delay in reporting because staff at the provider's head office had waited until the manager returned from leave before contacting the service. A staff member at head office told us that the manager had taken action to provide them with written guidance about safeguarding processes. They

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Is the service safe?

described this as helpful and said that staff in their department all had a copy. They said they were confident that any similar issues would be recognised and reported promptly in future.

Relatives told us that there were enough staff to meet people's needs. During our inspection we observed that staff responded quickly to people who needed support. We saw that there were enough staff to support people with activities in the local community and to attend a medical appointment. Staff also told us that, although they were busy, they felt there were enough of them to support people. They said staffing levels were flexible so that people could attend activities and appointments as necessary. We concluded that there were enough staff to keep people safe and meet their needs.

A staff member told us about their application and interview process and the checks that were made before they started work. They said they had provided information about their identity, employment history and references. The manager also told us about the information the provider gathered before staff were confirmed in their posts. We were able to verify this from the records for the staff member we spoke with. We concluded that recruitment procedures contributed to reducing the risk that people would be cared for by unsuitable staff.

We reviewed information about the safety of the premises. This was in the form of regular monthly monitoring visits completed on behalf of the provider and in maintenance and testing records. These showed that the safety of the premises and of equipment was checked and maintained. For example, the reports showed that tests of fire detection equipment, emergency lighting and the home's vehicles were maintained and up to date. Staff training in fire safety was also up to date based on these monitoring reports and the training schedule we reviewed. This helped to protect people from hazards in the home.

We reviewed the guidance available for personal emergency evacuation plans and discussed these with the manager. The plans recorded how people living in the home would react to the fire alarm sounding but were not clear about what staff would need to do to ensure each person could be evacuated safely in an emergency.

We recommend that the service considers current guidance regarding fire safety and means of escape for people with disabilities and takes action to update emergency plans accordingly.

Good

Is the service effective?

Our findings

A relative told us, "The staff I have met seem to be competent and helpful. They are always ready to answer any queries I have and to see that [person's name] is well looked after." Another said that staff were, "…definitely competent." Staff confirmed that they had access to training which helped them to meet people's needs effectively including core training such as in moving and handling, food hygiene and first aid. In addition, there were opportunities for further training related to people's specific needs such as epilepsy, autism and challenging behaviour. Records showed that training was monitored so that it could be renewed when necessary. One staff member commented that the organisation was good at training and felt that this enabled them to meet people's needs. A new member of staff told us that they had learnt from induction and from discussion with experienced colleagues about the support that people needed to maintain their health and personal care.

We observed staff handing over between shifts in each of the bungalows. Information was passed between staff about specific needs or issues affecting individuals and what needed to be followed up by the incoming shift. There was additional information about these issues recorded in a staff communication book or within the home's diaries. We concluded that staff communicated well with one another to ensure people received the care that they needed. We also observed that staff were able to understand people's efforts to communicate so that they could attend to any care that was needed.

We found conflicting information from staff about whether they received regular supervision to support them in their roles. Supervision is needed to ensure that the performance of staff can be discussed and any problems or development needs can be addressed. Half of the staff spoken with felt that they were supported properly and received supervision. The remainder felt this was not the case. Because of this conflicting information we reviewed the supervision schedule. We noted that staff had received appraisal but had not received supervision as the provider intended and in some cases not for over six months. However, we concluded from our discussions with staff, observations and information from relatives that staff had the skills they needed to support people properly and to carry out their roles.

Staff confirmed that they had received training in the Mental Capacity Act 2005 (MCA). They described how other important people such as the dentist, doctor and family members, were involved in assessing whether people understood any treatment that was needed. Staff told us that, if people were assessed as not able to give informed consent, the process helped to ensure that decisions about treatment were in the person's best interests. The ways that people communicated were recorded and attached to information for hospital admission in emergencies so that medical staff would understand how to best to assess people's ability to consent to treatment. This meant that the service was following the MCA code of practice and making sure that the human rights of people who may lack mental capacity to take particular decisions were protected.

Our discussion with the manager showed that she was aware of the need to ensure the principles of the MCA and Deprivation of Liberty Safeguards (DoLS) were adhered to. The MCA DoLS require providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty so that the least possible restriction would be used to promote people's safety. We concluded that the provider had properly trained and prepared their staff in understanding the requirements of the Mental Capacity Act in general, and (where relevant) the specific requirements of the DoLS.

We observed that people were offered choices about what they drank and ate. The menus we saw showed that people had access to a varied diet and a staff member went to purchase fresh vegetables while we were inspecting. Throughout our visit we saw that people were offered frequent drinks to ensure they drank enough. Staff told us about people's dietary needs, including the use of supplements, pureed foods and thickened drinks. They understood the importance of ensuring people were not at risk of aspiration. (Aspiration is the inhalation of food or drinks into the lungs when eating or drinking and can be fatal.) Staff were clear about which people needed to be supervised and how they would be positioned to minimise the risk of this happening. We observed that staff sat with people while they were eating and drinking to provide the support they needed.

Good

Is the service effective?

One person was receiving their nutrition and fluids through a percutaneous endoscopic gastrostomy (PEG) tube inserted through their stomach wall. Staff confirmed that they had training in the use and management of this so that the person received the food and fluids they needed.

We saw that staff responded appropriately to concerns about one person's weight loss. We noted that staff raised this at hand over, agreed an increase in monitoring and discussed ways of increasing the person's calorific intake. The person had also been supported to attend a GP appointment to explore whether there were underlying health reasons which might have contributed to this. Staff told us that they would follow this up to request a referral to a dietician if this was needed to support the person more effectively. We concluded that staff supported people to have enough to eat and drink to meet their needs.

The majority of relatives told us that staff were quick to recognise when someone's health might be deteriorating and to follow this up promptly. A relative told us, "When [person's name] has been unwell the staff have noted it quickly and responded well." Another relative commented, "I think sometimes it is difficult for newer members of staff to pick up signs that residents are becoming unwell. This is something that will improve as staff get to know the residents." We checked with feedback from a GP who was satisfied that staff consulted them appropriately and sought advice when this was required.

We observed that one person was prepared and supported to go to a dental appointment during our inspection and staff gave us examples of treatment that people had received. A nurse for people with a learning disability confirmed to us that they had been consulted about providing 'health books' and had met with the manager recently to discuss developing health action plans.

Our discussions and observations showed that staff demonstrated commitment to the welfare of people using the service. We concluded that they supported people in a way that maintained their health and promoted their welfare.

Good

Is the service caring?

Our findings

Relatives told us they were satisfied that staff were compassionate, caring and treated people with dignity and respect. One went on to say, "The atmosphere is always about help and support. I have always found that they are respectful of people." Another relative told us how a member of staff had revised their entire work schedule so that they could support the person when they were in hospital. They told us they felt this was very kind and had made the situation easier for the person who would otherwise have been very frightened about what was happening.

We saw that staff respected people's dignity. When people needed assistance with personal care staff ensured they were discreet in their approach and delivered personal care in private. We observed that staff spoke with people respectfully and in a kindly manner. We saw that one person approached staff for contact and reassurance. A staff member put an arm around the person's shoulders and made eye contact while they established what the person wanted. A GP also confirmed that they felt staff were caring towards people both when they were attending appointments at the surgery and when the GP had visited people in their home.

Staff told us how they tried to present information to people in a way they would understand. We observed that they were able to communicate with people who found this difficult. We saw one staff member engaged in conversation with someone who had a speech impediment. Other staff told us how one person used signs to communicate and was able to make their views known. A speech and language therapist told us staff had responded promptly to their advice about communication to increase opportunities for people to make decisions and choices about their care.

Staff told us that two people attended religious services within the home if they wished. They understood this might be important to these people because of their family histories. Staff also gave us different examples of how people's levels of activity during the day time might impact upon them. They said sometimes people might not be as responsive after a very active day and might need encouragement to rest. This meant that staff showed concerns for people's wellbeing.

We observed that one person was encouraged to take their cup to the sink when they finished their drink and another was gently prompted to wash their hands when they returned from using the toilet. Relatives told us they felt that people were encouraged to do what they could for themselves and we concluded that efforts were made to encourage people to be as independent as possible.

Staff told us about people being offered choices every day. They said that people could choose what to do, where in the home they wished to spend their time, and what to wear. Relatives also told us that staff gave people opportunities to make choices in their daily lives. We observed that women living in the home were supported to wear jewellery if they wished. One person showed us the bracelets they were wearing. We saw that people were wearing clean and coordinated clothing.

We observed that cabinets containing personal information were locked when they were not in use. We also observed that staff conducted the hand overs between shifts in private so that people living in the service would not be able to hear personal information relating to others. Staff referred to people in a respectful manner when they were sharing information with their colleagues.

We concluded that people's right to confidentiality was promoted and staff treated people with compassion, kindness, dignity and respect.

Requires Improvement

Is the service responsive?

Our findings

Half of the relatives commented that they felt that staff understood people's needs and preferences. The remainder told us that they were concerned that newer or less experienced members of staff had difficulties with understanding people's needs. We spoke with one new member of staff who felt that they could meet people's needs and would get information or advice from their colleagues if they were unsure of anything. Staff were able to tell us how they supported people with their care and activities they knew people were interested in. However, staff did not have access to individual plans of care, including people's history, preferences and aspirations. This meant that there was a risk of staff not being able to deliver care that was specific to each individual.

Relatives said that people were supported with a variety of activities, inside and out of the home, including holidays and parties. During our visit, three people went out separately with staff to look round the local town, to go for a coffee or to shop for what they needed. Another person went to a medical appointment and then on to do some clothes shopping. Two staff members gave us an example of an activity they had supported someone with but which had not gone well. They told us that the person concerned enjoyed music but had not liked attending a concert. The staff involved had identified what they could change in future. This showed that they had responded to the person's specific needs so that they would have a better experience.

People's cognitive and communication difficulties meant that they would need assistance from family or staff to raise concerns or complaints. Half of the relatives told us they were confident that the registered manager would deal with any issues they had. One said, "I know she's only at the end of the phone line if I need anything." However, others were not confident that their concerns would be addressed and felt that the manager did not always listen to them. One said, "I do know how to raise concerns but I feel that the present manager does not take into consideration the points that one raises." They went on to say, "My concerns about [issue] have not been addressed since I went to see [the manager] at the beginning of this year." We concluded from the views of relatives that issues raised as concerns rather than formal complaints were not always recognised so that the service listened and learnt from them.

Most relatives told us they knew how to contact the provider to make a formal complaint. One relative told us, "If I don't get a satisfactory response I know where to go next up the route. I don't feel in any way gagged." The last formal complaint received was received and investigated in 2006 and there was a process in place for responding to them.

Requires Improvement

Is the service well-led?

Our findings

We found conflicting views about the way relatives felt the service was being run. A relative told us they felt management changes had affected staff morale and had "…rocked…" the confidence of some staff. They went on to say that they felt this would have happened anyway as a result of the changes. The told us the previous manager had been in post for a long time and staff needed to get used to the style of the incoming manager.

However, most relatives expressed some anxiety about leadership in the service. For example, one said of the manager, "I don't feel that she takes on other people's ideas and opinions. I feel that she believes she has the experience to make decisions on the lives of the residents before she has really come to understand their individual needs. I do not think that this has worked." Another told us, "I don't think she has got to know the residents yet. She doesn't spend time in the bungalows so should listen to staff with experience. When she first came she left it to staff to get on with it. Since then she won't listen about what may not work very well and isn't there when problems arrive."

Four of the staff we spoke with told us that they felt valued and supported in their work and received feedback from the manager about the way they were working. They felt they were able to raise issues with the manager. However, four other staff said they did not always feel valued or appreciated for good work but and got criticised when things went wrong. They told us that they did not feel able to express this to the manager or line manager in case this caused them further problems in their working relationships. They said that they felt morale had deteriorated since they completed their staff surveys and some staff became upset about this during their discussions with us. They acknowledged that adjusting to the change of management had been difficult but did not feel confident in discussing this with the manager and did not think it would make any difference.

We concluded from the feedback we received that changes, vision and values had not been discussed and shared in a way that all staff felt committed to or felt able to challenge. The impact of this on staff morale meant there was a risk of staff turnover increasing and affecting the quality and consistency of care people received.

Our discussions showed that staff were aware of their obligations to blow the whistle on poor practice. However, they told us that they did not have access to the provider's guidance for this in the bungalows they worked in. They felt they would have to ask to access the guidance to raise any concerns with the provider; they were anxious this would identify rather than protect them if they needed to blow the whistle on poor practice. This presented concerns that the culture within the service was not sufficiently open and the provider may not be made aware of poor practice affecting people's care and welfare.

Regular visits on behalf of the provider were taking place to monitor the quality of the service. However, the most recent report compiled on behalf of the provider indicated that staff supervision was up to date. It did not identify that supervision was not being delivered in line with the provider's own policy to address development needs or performance and to share information. Quality monitoring visits had also not identified that the management of some medicines could not be properly audited so that systems could be effectively monitored to ensure their safety.

We spoke with the manager about the shortfalls in records and information available to staff regarding people's care, including individual plans of care and risk assessments. Some of the information had not been available for staff to refer to for a period of six months. The manager said that she had not been aware of the length of time since the removal of the information from staff offices and that some of it may have been lost in the bungalows. The absence of these records had not been identified in the monthly visits on behalf of the registered provider and compromised the ability of the service to deliver safe and high quality care.

Relatives confirmed that there was a 'Friends of Kittens Lane' group although this was primarily for the purposes of fund raising. The majority of relatives confirmed that they were confident they could raise any issues about service quality but they did not feel they had been asked to comment about the quality of the service.

These concerns demonstrated a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked the manager how incidents were analysed. The manager showed us a report compiled to see whether there was a pattern of incidents or accidents for an individual. She explained how the analysis looked at

Requires Improvement

Is the service well-led?

whether there were any underlying causes relating to the person's health and whether there was any correlation in the times of day incidents took place. The information had been prepared for an appointment with a neurologist. This showed that efforts were made to analyse incidents so that improvements could be made if necessary.

We recommend that the service seek support and training, for the management team, about motivation and team building.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers 10(1)(a) and (b) The registered person did not have effective systems to regularly assess and monitor the quality of the service and protect people against risk. 10(2)(iii) The systems for monitoring the quality of the service did not have regard to the records referred to in Regulation 20.