Consensus Support Services Limited

The Pines

Inspection report

Culford Road
Fornham St Mary
Suffolk
IP28 6TN

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place over two different dates the 10th and 12 February 2016 to meet with as many people as possible using the service. The first day was unannounced but the second day was agreed with the registered manager.

The service provided accommodation for up to twelve people and was divided into three separate living quarters to give people further independence according to their needs. Adults had a diagnosis of learning disability, mental health needs or both and were supported in accordance with their needs.

There was a registered manager in post who had been in post in excess of three years.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service provided accommodation which was designed to accommodate differing needs including those who were more able and those who needed more assistance. Each part of the accommodation was self-sufficient other than the laundry which was shared. Despite this set up it was not clear how staff were always meeting people's needs effectively around their individualised needs and according to their wishes and abilities.

Medication administration was carried out by staff who were sufficiently supported to ensure they had the right competencies and skills.

Risks to people's safety were documented and as far as possible effectively managed.

Staff recruitment was robust and there was good support in place for staff. Their training was up to date but limited access to more specialist in-depth training around mental health and learning disability training meant we could not be assured that staff had the necessary skills and sufficient understanding of individuals.

Staff had a good understanding of legislation relating to the Mental Capacity Act 2005 and the Deprivation of Liberties. The MCA ensures that, where people have been assessed as lacking capacity to make decisions for themselves, decisions are made in their best interests according to a structured process. DoLS ensure that people are not unlawfully deprived of their liberty and where restrictions are required to protect people and keep them safe, this is done in line with legislation.

People were supported to eat and drink sufficient to their needs and staff worked hard to ensure people received the health care they needed and staff monitored people's health and acted accordingly.

Staff interactions with people were not always as positive as they could be and staff were not seen to promote people's independence as fully as they might. Some people did not seem to have sufficient interaction or opportunity to participate in a fuller life as possible. Other people who could be more independent were not given the fullest opportunity.

People were consulted about their care and support. Regular reviews and an effective complaints procedure meant gaps in service provision could be identified and rectified.

Support plans were sufficiently detailed but did not always give specific guidance for staff to follow. Support plans were kept under review.

The service was well led with robust audits and quality assurance systems. Staff felt well supported and records were up to date. However the experiences of people using the service could be improved upon.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Processes were in place to ensure people received their medicines safely and staff received adequate training.

Risks to people's safety were assessed and where possible minimised by actions taken by staff.

Staff knew how to safeguard people in their care and who to report concerns to. People using the service were aware of who to raise concerns to.

There were robust recruitment procedures in place to ensure staff selection was suitable to the needs of the service.

Is the service effective?

Good

The service was effective.

Staff were supported in their role and received training and supervision but more training was required around people's specific needs.

People were supported to eat and drink enough sufficient to their needs and this was monitored.

Staff had a good knowledge of the Mental Capacity Act and Deprivation of Liberties. People were supported lawfully.

People were supported to access health care services and their health care needs were understood and sensitively met.

Is the service caring?

Requires Improvement

The service was not always caring

Staff practices were not consistently good and staff did not always act in a way which fully promoted people's independence and rights.

People were regularly consulted about their care needs and

about the service they received so this could be adapted as appropriate.

Is the service responsive?

Requires Improvement 

The service was not always responsive.

The range of activities for people was limited by a number of factors including staffing levels, transportation and the range of different needs people had which was not conducive to individualised care.

Person centred support plans were in place and reflected people's needs and kept under regular review. Plans were followed and helped staff to measure people's progress against agreed goals.

There was a robust complaints procedure in place and people knew how to access it.

Is the service well-led?

Good 

The service was well led.

The manager was knowledgeable and had appropriate skills.

There were detailed quality audits used to determine the overall safety and quality of the service provided. There were also quality assurance surveys which took into account people's views of the service. However we found through observations that staff interactions could be better.

The Pines

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 two dates, the 10 and 12 February. The inspection was unannounced on the first day and with the agreement of the manager on the second date. The inspection was undertaken by two inspectors. Prior to the inspection we reviewed the information we already held about the service including previous inspection reports and notifications which are important events the service are required to tell us about.

As part of this inspection we carried out a medication audit, looked at care plans, staffing records and other records relating to the management of the service. We spoke with four staff, the manager, seven people using the service, two health care professionals and requested some additional information. We also 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 easily or chose not to

Good

Is the service safe?

Our findings

The service was adequately staffed on the day of our inspection. The manager told us they were fully staffed apart from one vacancy which they had recruited to. There were at least three staff on duty at all times except nights when there were two staff. In addition the manager was on duty throughout the week and at other times when needed. The service did not require agency staff, as shortfalls due to sickness were covered in house which meant people received continuity of care. Staff rotated from day to night shift which meant they were familiar with people's needs. Some staff we spoke with were working long hours such as 14 hour shifts. However staffing hours were managed effectively to ensure staff got sufficient rest periods. Some people had additional funded hours which enabled staff to provide one to one support.
However for those without additional hours it was hard to see how their needs were always being met.

There was an on call system in place and staff said they could access support as and when required. Staff told us the manager was always responsive. There were emergency continuity plans in place for a range of emergencies such as in the event of a fire or other disaster.

There was information on display in the service about keeping safe and who people or their visitors could contact if they had any safeguarding concerns or complaints about the service. Most people would be able to raise concerns but other had named professionals supporting them with different aspects of their lives. The staff had involved an independent advocate to support an individual to move out and ensure the person and their interests were fully recognised and supported. The manager said advocates would be appointed as required.

Staff understood how to keep people safe and who they should report concerns to if they were told about a safeguarding situation or observed abusive practice. They said it was covered in team meetings, one to one supervisions and they received safeguarding training. The home referred to the adult safeguarding team and told us that they would only investigate themselves when asked to. The manager told us that internal safeguarding investigations were done jointly with other managers to ensure the investigation was sufficiently robust. A number of safeguarding concerns had been raised mainly in relation to medication errors and appropriate steps had been taken. We were concerned that a number of people told us they had been 'told off by staff.' One person said it was because they burnt the dinner. We told the manager about this so they could observe staff interactions to ensure they were appropriate to people's needs. The manager assured us that staff did not tell people off but it was the perception of people. We did have some concerns about staff engagement which we have reported on in another section.

There was a robust recruitment process and staff were not appointed until all the necessary checks were in place including: references, job application, and proof of identity, address and criminal records check. The interview process tried to ensure that only suitable staff were employed. It consisted of both written tests and interviews which included scenario's relevant to the service and input from people that used the service as to what was important for them.

Improvements had been made in the way people received their medicines. A number of medication errors

had been reported prior to the inspection and this had resulted in robust action being taken to ensure people were sufficiently protected from incorrect medication administration. There was an improvement plan in place showing how medication errors were being addressed. Stock checks and counting of tablets were occurring four times a day at each medicines round. This had resulted in no further errors being made.

We spoke with people about their medication. One person said staff helped them with their medication, and they were not allowed to take it themselves .Another person said they got their medicines as required but did not know what the medicines they were taking were for.

People had medicines kept safely in their own room and keys were kept separately by staff and administered at the prescribed time. Records were kept of the temperatures of the individual drugs cabinets. There was specific information held for each person in relation to the medicines they were taking, what they were for and any special instructions. The GP's were responsive to people's needs and if a person took a medicine for more than three days this was added to their regular medicines. Medicines were prescribed according to a person's needs so for example if a person needed medicines in a liquid form this was supplied. The service had a homely remedies policy.

In addition to the daily counting of tablets monthly medicine audits were completed and there was evidence of external medication audits as well. We raised a concern that no one took their own medicines and the manager said there was a process in place to assess people's capacity to do so.

Staff told us they had completed both on line and face to face medication training. They said when first giving medicines they were shadowed by a more experienced member of staff and that a number of observations of their practice were carried out before they administered medication by themselves.

Good

Is the service effective?

Our findings

People receive care from staff who have the knowledge and skills they need to meet people's needs. However more support was needed for supported in managing people's mental health.

We spoke with staff who felt they were well supported in their employment and had the necessary skills they required for their role. New staff told us about their induction when first starting work. They said the first week was spent familiarising themselves with key policies and procedures. They also completed training essential for their role. Some of this was through e-Learning which they completed at the service and other training was face to face including MABA which was training designed to support staff in effectively managing actual or the threat of aggression. Staff told us that the training was designed to use the least possible amount of contact but to give staff the skills to deescalate a situation before it escalates. A number of people using the service could potentially act in a way which put them or other people at risk of harm so this was essential training for all staff. Staff also had training on how to use the support plans and health action plans and meet the needs of people with a learning disability. There was a separate module on epilepsy because some people using the service had epilepsy. There was also training on mental health. Staff told us they had recently completed a five hour dementia course which they had found helpful in understanding people's needs. Two people had dementia at the service but only one with a formal diagnosis.

We looked at the training matrix for staff which showed 98% of training was up to date. We asked about more specific training around people's individual's needs. Examples given to us included end of life and nutrition. The manager had completed additional training including information governance, an enhanced safeguarding course for managers, The registered managers award, immigration training and person centred training.

Staff told us that they had a six month probationary period in which they were supported through training, supervision and annual appraisal. These were planned out throughout the year.

Staff told us they had a mentor and were being supported through an induction programme called the 'care certificate' which covered new minimum standards care workers should cover as part of their induction. All but two staff had completed additional vocational courses. The manager told us there was also a buddy system for new managers to ensure they were adequately supported.

Staff said that they were keyworkers to people which meant they oversaw their needs and attended reviews for the person they were supporting. They said some staff had additional responsibilities such as for health and safety; all staff gave medication when assessed as competent to do so.

People's health care needs were met as far as possible. Care staff gave us examples of how they had supported people to access appropriate health care services with the support of the liaison nurse at the hospital who specialised in supporting people with learning disabilities. A number of people had needed additional support to understand their medical condition and the options available to treat it. Staff had

invested the time to put together information and support people in making a decision. The health care section in people's care plans was robust and showed people were supported to maintain their health and were seen by a range of health care professionals at regular intervals.

People had routine health checks including well women/well men checks and staff were very supportive of people's health care needs to ensure that people's well- being was promoted. People had very detailed action plans and information about their needs should they need to go into hospital. Staff accompanied them to hospital ensure their needs would continue to be met.

Staff told us they had good links with health care professionals and they were supportive of the people living at the service. Staff gave an example of one person who had a phobia about visiting the dentist but with a lot of time and support had recently agreed to have a filing.

The manager had a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty DoLS. A number of people had been assessed as unable to go out safely and to that end were being restricted for their own safety. One person had sensor alarm which meant staff were aware when they were mobile and this was considered the least restrictive way of monitoring this person for their own safety. Staff told us they had training on the MCA and DOls and had sufficient awareness of how to support people appropriately. They told us they worked closely in conjunction with other health care professionals to ensure their needs and rights were upheld.

We observed lunch on one day and dinner on another. People using the service had some involvement in meal preparation but we did not see people's choices being adequately promoted at lunch time. Staff told us they had pictorial menus to help people choose their meals but these were not used on the day of our inspection to promote people's choice. However people told us how staff supported them with their dietary needs and supported their involvement in cooking. One person told us their speciality was a roast, (Yorkshire puddings.)

Staff told us that they were currently supporting several people with healthy eating and did monitor people's weight and how much they drank when this was felt necessary. Some staff told us they had received training around supporting people with their nutritional needs. Two people had diabetes and there was information for them about alternative low sugar or no sugar alternatives they could choose. They were regularly supported by the diabetic nurse and their feet were checked regularly.

Requires Improvement

Is the service caring?

Our findings

People were supported to keep in touch with their family. Some relatives visited the service and staff accompanied people to meet up with family members. One person told us, "The staff help me spend time with my friend." Another told us they regularly skyped their family member. One person told us they were supported to keep in touch with an old partner. One person told us staff supported them to meet up with a friend and this was diarised so staff support could be made available.

Staff interactions were largely task based. One person was largely unoccupied throughout the first day of our inspection and their daily records showed that on most days they had very little stimulation. They were observed sleeping for a lot of the day but staff told us they had recently been unwell and were still recovering. They also said due to advanced age the person was no longer very active. There was very little observed staff interaction other than around assisting them with their personal care needs. Staff missed opportunities to engage with them when they appeared calm and receptive. Staff sat at the table and some people using the service returned from an activity and sat in the lounge which is adjacent to the dining area. Staff did not go and sit beside them. We observed staff making themselves drinks without offering people a drink. One person made another person a drink but was then seen to carry it across the room; the cup was very full and very hot. They had not been supported appropriately by staff. There was a risk assessment in place for this person but it did not include the risk of scalding or how this potentially could be reduced for the person.

Another person fell to their knees and we were told they were prone to falling and this was part of their overall behaviour. However we had observed them being unsteady of their feet and their mobility reduced. They complained of pain in their knees and staff did offer pain relief. Staff told us it was part of their behaviour as a way of seeking attention but we did not see staff giving them positive attention prior to this fall.

On our second day we carried out an observation for over half an hour when people and staff were in the lounge/dining room. We observed some good interaction with staff supporting people with one to one activities such as puzzles and craft. and staff initiating conversation with a person who was looking at a book.

Staff were observed asking a person if they had their bowels open today, this was not said discretely and could be heard from the other side of the room in front of people.

People's independence was not always promoted. We noted through our observations of meal times that there were no condiments on the table and half way through the meal people were asked if they wanted sauce. This was brought through and put on people's food for them. A health care professional said they did not feel one person was sufficiently supported to see their family member and were not encouraged to use public transport so they could make this journey alone. This did not uphold people's independence. However the service had taken steps to support this person and visit their family and also where possible use public transport.

Systems were in place to obtain feedback from people and it was clear the manager was proactive in monitoring the service and dealing with matters brought to her attention. Resident's meetings and one to one key worker meetings took place as well as regular reviews.

We viewed a number of monthly monitoring visits. One referred to a person not being happy with the way staff had spoken to them. This had been addressed by the manager. Feedback from people using the service as part of the last quality assurance survey in August 2015 reflected a 100% return rate and a 95% satisfaction rate. Comments had been received from staff, relatives, and people using the service. During our inspection we received feedback from a number of professionals who had raised concerns about the service and felt it did not always provide a good service in terms of activities, sufficient staffing or in the way some staff spoke with people. This was contradictory to the findings by the service. However we also viewed comments from a number of health care professionals which were extremely complimentary about the service and actions taken to meet people's needs.

Requires Improvement

Is the service responsive?

Our findings

People's experiences and our observations of how well people's needs were met were mixed. We spoke with a number of people using the service. One person showed us their room which was set up in a way that reflected their hobbies and interests. They told us they liked the cinema and staff took them. They told us they helped out at a charity shop and enjoyed this. However other people's experience were less positive. One person told us," I don't like it here and would like to move on." Another person told us that they did not like living there as there was a lot of conflict between individuals.

In the lounge was a profile of all the staff and people using the service This told us a bit of personal information about everyone including hobbies and interests. Staff said this helped when thinking about which staff should support a person as their key worker or with a specific activity.

People in one flat referred to the conflict that took place. One described it, 'As bombs going off constantly.'

Staff said that people had structured activities during the day which were organised around their specific needs. Some people went to the info bar which was a cyber café where people could meet and also see information about different things going on including adult education. The service had facilities like a pool table. One person went as a volunteer to the local park/managed green space managed by the council. Another person worked in a charity shop One person said they did yoga, went swimming regularly and had been to a number of concerts with family members. Other activities included a valentine's disco which 11 people were going to supported by four staff. Trips out such as Duxsford, the zoo, and the Norfolk Broads took place but according to staff only about four times a year. People had day trips rather than individual holidays but we were not clear as the reason for this. Some people regularly supported by family. One person told us about lots of things they had done with their family members.

Some people had agreed house rules and people were responsible for their own laundry with set laundry days and were helped by staff to cook their meals. People told us there was a menu which they could choose from and decide what they wanted to cook with support. For example one person said they were making vegetable pie with home- made pastry. Another said they had chosen to cook fish fingers.

Staff told us about how some people had progressed at the service including one person who had not been out for about 40 years without the need for sedation and now was able to access a range of community facilities with the support of staff. However another person was being supported to move on and health care professionals felt their skills had decreased since being at the service.

We were concerned about one person's inactivity. Staff said they could be reluctant to go out and did not like living in a 'group situation,' and reacted when being expected to go out with other people living at the service. Staff told us they did not like noise. They sometimes required two to one staff support to accompany them to health care appointments.

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We observed this person spending most of their time at the service without regular access to the community and with very limited structure to their day. Staff said this was of their choosing but there was no evidence that staff were offering meaningful alternatives and doing all that they could to promote a more positive experience for this person. For example the person had little to engage them throughout the day and it was 'accepted' they would spend their time in bed in the morning before getting up, their afternoon and evening was spent mostly watching television. There was little else offered and they ate their meals alone in their bedroom with the door shut. .

Their support plan said that a good week for this person would be lying in bed and watching television and there were no positive references as to what the person enjoyed, responded to well or whether they related better to a particular member of staff or a particular activity. We felt that staff were risk adverse and missed occasions to sit with them and engage with them when they were receptive to this. Their daily notes showed them doing very little and we could not see how their needs were being met.

We saw for another person very limited activity recorded in their daily notes. We looked over the last three days and they were at home watching television. This was a person described as sociable and liked going out.

Prior to admission to the service people's needs were assessed to ensure the staff had the necessary skills to meet them. However we found there were a number of limitations to what the service could provide and how individualised the care and support was. Assessments did not seem to take into account the compatibility of people living together although it was acknowledged that one person was admitted to the service as an emergency admission so there might not have been sufficient information available. Some people sharing their living accommodation did not really get on with each other. This resulted in arguments and people taking themselves to their room because they did not enjoy each other's company. During the day/evening people sometimes attended the same activities which appeared to be around staffing levels and the availability of transport rather than around the needs of the individual.

We spoke with three out of four people sharing one flat. They told us about the arguments. They said two people got on but did not get on with the other two people living in the flat. Visiting professionals felt that the atmosphere was putting a strain on people living together. We spoke with one person who explained the tensions and disagreement they had. They said, 'I say things I don't mean' They told us if they could not calm down they were taken to their room and if they still were unable to calm down within a specified period of time they were offered prescribed when necessary medication to help them to calm down. The manager said they had a relaxation chart in their room and that the PRN protocol was for severe agitation. Behaviours included: shouting/screaming/banging doors. The PRN protocol had been signed/agreed by the physiatrist and reviewed. However the protocol had not been signed or agreed by anyone else including the person who was being administered the medication.

We felt that some of the person's behaviour could be escalated by living with other people they did not get on with because of their different needs. We asked the person what helped calm them down without the use of medication and they said by staff talking to me. They then said they did not get on with all the staff and that some staff told them off. They told us they just wanted the arguments to stop. Staff did not clearly analyse and monitor people's behaviour to see what additional steps could be taken to deescalate behaviours in the most positive way. ABC charts were used which meant antecedent, behaviour and consequence. These helped staff analysis potential triggers for behaviour and what could be changed to reduce the unwanted behaviours and what interventions were successful in reducing behaviours. The records we saw did not take into account all the factors such as the dynamic between different people using the service and the level of inactivity for some people which could be a factor in poor behaviours.

The manager told us prescribed when necessary medicines for behaviour/anxiety were recorded on the medicine recording sheet, daily notes and behaviour records. They said they were not used excessively but we could not see from the information if they were always the most effective means of supporting a person with their behaviour and records did not show a more holistic approach. The manager said they had completed in depth training in ABC charts and this was relayed to staff.

Some people had previously lived independently but due to individual circumstances now required a bit of additional support prior to moving on to more independent living. People's care plans did not always reflect how people were being encouraged to become more independent. For example no one was managing their own finances in relation to budgeting, their own medicines, only one person was accessing public transport which meant people were restricted and depended on staff for transportation. Some people had been able to use transport independently before moving into the service. No one was attending college although one person had said they would like to. The provider told us people have attended courses and they were looking at different activities and courses available in the near future.

Staff told us there were handovers between each shift so they were up to date with any changes to people's needs and what needed to be done. Staff told us people's needs were accurately recorded and kept under regular review. Staff told us there were regular key worker meetings every four to six weeks and each year there was a formal review of the persons support and goals set. Staff told us these were attended by anyone one involved in the persons support, such as health care professionals, family and the person themselves. People had health care reviews and reviews of their medication.

We looked at a number of support plans and they told us what people were able to do, what they enjoyed doing and what they needed help with. They included one page profiles which were informative and gave us a good description of the persons attributes, character, likes and dislikes. We found support plans detailed but lacking in specific guidance for staff to follow. For example one plan read, "Staff should get to know what causes me to get upset and how I behave at such times."

Some of the documentation we saw was not up to date and did not reflect people's current needs. For example one person had a learning disability, mental health issue and onset of dementia. Their needs had been reviewed by a psychiatrist in respect to their medication for behaviour and anxiety but it was not clear how the person behaviour was currently being managed effectively or positive strategies for managing behaviour. Their care plan stated they did not like close contact/interaction but staff were able to take them to the hairdressers. We also noted that there was a question about whether the person might be hard of hearing and staff should write things down. Given the diagnosis of dementia we asked if the person had any means of connecting with their past such as life stories. This was not in place. The provider told us advice was give by the Psychologist & clinical Neuropsychologist and staff training had been provided.

There was a plan in place written by our positive behaviour team to manage behaviours. We also looked at the persons care plan who had a tendency to throw themselves on the floor. Their care plans showed input from an occupational therapist and steps taken to support their mobility and their tendency to throw themselves backwards. The person through our observation had fallen forward. We saw from their records that they had a number of falls and could not ascertain from their records if they were purposefully falling or falling as a result of poor mobility. We asked the manager about their mobility and they said they used a walking frame whilst out and about but not in the house. We had observed them earlier coming into the house and they were not using a frame and did not do so from the bus. .

People told us they knew how to raise concerns and would go to staff or members of their family. There was a clear complaints procedure and people could be supported to raise concerns they might have. There were

two complaints recorded for 2015 and these had been responded to appropriately.

Good

Is the service well-led?

Our findings

Staff told us the manager had an open door policy and was supportive of staff and took the time to listen and help out when needed.

The manager was well qualified and told us they felt well supported. They told us the organisation was proactive in terms of training and supporting their managers. They said there were monthly managers meetings. They attended conferences around the changing legislation and the new CQC ratings inspections. They said their own quality assurance processes were structured around the way CQC inspects care homes. They said the organisation were proactive, they gave an example of using 'survey monkey' which is on online system to obtain and record feedback. One had recently been completed for staff to ask for some feedback as to why staff had left their employment. This was geared at identifying what motivated staff and how staff retention could be improved within the organisation. The previous year a national award ceremony had taken place to share and celebrate good practice. The manager told us there was no financial incentives for staff undertaking additional training but the organisation were looking at pay scales and promoting staff within. The manager said best practice groups were held every two months to review polices in line with best practice.

There were systems in place to audit the service which were done by the manager and regional manager. Internal audits scored highly over 90%. We saw the results of the last annual quality assurance survey dated August 2015 with an overall score of 95%

The manager told us people's needs were kept under review and reviews were initiated by the service and were inclusive. At these reviews other people were invited and the staff would go through what people had done in the last year, what they wished for their future, and their aspirations. The manager told us residents meetings had been replaced by one to one key worker meetings every three months and these were recorded. Residents meetings were only held if there was something specific to discuss.

Events affecting the well-being and, or safety of people using the service were recorded and actions taken was logged. This included a number of recorded medication errors.

Relations with other health care professionals and the community were reported by the manager as good but some feedback we received about the service was mixed.