Complete Community Support (East) Limited

Stable House Colchester

Inspection report

Stable House
Cockaynes Lane, Alresford
Colchester
Essex
CO7 8BZ

Tel: 01473747247

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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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on the 25 May 2016 and was announced.

Stable House, Colchester is registered to provide personal care for people with a learning disability. On the day of our inspection there were six people using this service, all living within the same housing complex, in separate flats within the one location based in Ipswich.

It was evident during our inspection that the service was not being managed on a day to day basis from the registered location Stable House in Colchester but was being run from Norwich Road in Ipswich where the manager and staff were based. This was also the location which was the point of contact for people who used the service. Following our inspection we asked the provider to explain why the Norwich Road should not be registered as a separate location to Stable House Colchester.

There was a registered manager. 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.

Relationships between staff and people were relaxed and supportive of their needs wishes and preferences. People who used the service were actively involved in making decisions about their daily care and support. Staff sought the consent of people in the planning and delivery of their care. Staff promoted and supported people's independence and enabled them to have access to the local community.

Where risks to people had been identified there were plans in place to manager them effectively. Staff understood the risks to people's health, welfare and safety and followed guidance to support people appropriately.

The suitability of staff to form caring, supportive relationships with people was assessed as part of the provider's recruitment process. People who used the service had been involved in the recruitment and selection of staff. People could be assured action had been taken to check that newly appointed staff had the necessary skills and had been assessed as safe to provide their care and support. However, on occasions people did not always receive their one to one care support as assessed to meet their needs due to shortages of staff available.

People received care that was respectful of their needs for dignity and their privacy was respected.

People were protected from social isolation because they were supported and their relatives told us that people were supported to follow their own hobbies, interests and received support with opportunities to access further education at college, day services and community activities.

People had a support plan which reflected their personal choices and preferences regarding how they wished to live their daily lives. Support plans were contained comprehensive information but were bulky with out of date documents and were not always recorded in a personalised format that the people who used the service could understand.

There was little evidence of any formal systems where the views of people were regularly sought . Tenant meeting and care reviews were sporadic. This meant that further work was needed to ensure there were systems to support people to air their views and used in planning for continuous improvement of the service.

The provider did not operate effectively an accessible system for identifying receiving, handling and responding to complaints.

We were reassured that action was being taken to respond to issues of disunity amongst staff and action planned to improve the culture of the service. This included planning in place to work towards resolution of the cultural issues that had been evident for some time.

During this inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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.

There was not always sufficient staff available to meet people's one to one allocated support care needs.

The provider had a whistleblowing policy and procedures were in place to guide staff in how to report concerns appropriately.

People's likelihood of harm was reduced because risks to people's health, welfare and safety had been assessed and risk assessments produced to guide staff in how to mitigate these risks and keep people safe from harm.

Safe systems were in place to provide people with their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were not always provided with opportunities in accordance with the provider's policy to discuss their work performance and plan for their training and development needs as supervision support was sporadic.

Staff had limited understanding of their responsibilities in relation to the Mental Capacity Act (2005).

Care and support plans recorded people's specific dietary requirements, preferences and any food allergies.

People were supported to access a range of health and wellbeing services.

Is the service caring?

Good

The service was caring.

People were treated with kindness, compassion and their rights to respect and dignity promoted.

People were supported to make decision about their daily care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The provider did not operate effectively an accessible system for identifying receiving, handling and responding to complaints.

People were supported to live life to the full and to follow their interests and hobbies as much as they were able to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The morale of staff was low. We were reassured that this had been identified by the management of the service and action was being taken to address the disunity amongst staff and improve the culture of the service.

There was a system of regular management audits which monitored all aspect of the service to check for safety and effectiveness.

Stable House Colchester

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.

This inspection took place on the 25 May 2016 and was announced. The provider was given 48 hours' notice because the location provides a supported living service and we needed to be sure that someone would be in when we visited.

This inspection was carried out by one inspector.

Prior to our inspection we reviewed information we held about the service, in particular notifications about incidents, accidents and safeguarding information. A notification is information about important events which the service is required to send us by law.

We spoke with three people who used the service and following our visit spoke to four relatives on the telephone. We interviewed four staff, the supported living manager and the registered manager.

We reviewed two people's care records including their support plans, staff recruitment files, staff training and records relating to the quality and safety monitoring of the service.

Requires Improvement

Is the service safe?

Our findings

Everyone we spoke with told us they felt safe with all the staff who supported them. One person said, "I feel safe with everyone. They [staff] are good to me. Another said, "I am free to speak my mind and I love my freedom here."

One relative told us when asked their views about safety of the service, "I have never had any concerns about [relative's] safety until recently when I have become concerned about the lack of security to the building when anyone can walk in. The staff don't always ask for ID. This has caused me some sleepless nights worrying." Another told us, "I think [relative] is cared for but there is not always enough staff to provide the safe care they need."

All of the relative's and people we spoke with told us there had been several recent occasions when there was insufficient staff available to provide people with their one to one allocated care. We also noted from a review of management audits where it had been identified that people did not always receive their one to one support due to insufficient staff available.

One relative told us, "Staff don't always turn up for their shift or they leave it too late to find cover. My [relative] has not always received their medicines and they do not always get the one to one support they need." Another told us, "They are often short staffed especially at weekends and people don't get the care they are supposed to."

Staff told us there was occasional use of agency staff but this was discouraged by the provider as costly and agency staff did not provide people with consistency of care. Staff told us that they worked as a staff team to fill vacant shifts with the manager supporting them as best they could, to enable people to be supported with staff familiar to them. Staff also told us the rotas were not always managed well which resulted in staff not being contacted with sufficient time to find cover and shifts went unfilled. The management team told us there were no current staff vacancies but confirmed staff absences could not always be covered. They told us they managed as best they could with existing staff picking up extra shifts where they were able to but admitted this did on occasion impact on people's ability to receive their care package as assessed to meet their needs.

We asked the provider if they had a system for logging the occasions when there was insufficient staff to enable people to receive their allocated one to one support. They told us they used to keep a log of these occasions but no longer did so. This did not reassure us that the provider was collecting information for tracking, and analysis of these incidents to determine the impact on people and with a plan of action for improvement of the service.

This demonstrated a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw from a review of records and discussions with staff that they had been trained and were able to

demonstrate their understanding of what steps they should take to safeguard people from the risk of harm. Training provided staff with the required knowledge they needed to recognise the signs of abuse and what action they should take in response to any concerns they might have. Staff were aware of the provider's whistleblowing policy and understood the procedures to follow if they had concerns about people's safety and wellbeing. Notice boards contained information to guide staff in how to contact the local safeguarding authority should they need to do so. There was also information available for people who used the service in an easy read format to enable them to understand how to recognise and respond to acts of abuse.

Risks to people's safety and welfare had been assessed and actions taken to reduce these risks whilst supporting people's choice to take informed risks. Staff understood what measures were in place to mitigate any risks to people's health, welfare and safety. Risk assessments had been produced for a range of situations. For example, accessing the community, the management of people's medicines and guidance for staff in responding to occasions when people presented with extreme anxiety and distressed reactions to situations or others.

The provider had procedures in place to guide staff in the event of emergencies. Accidents and incidents were recorded and analysed by the provider. Staff were supported out of hours with an on call duty rota where they could access management support and advice when required. Staff told us this system had worked well in supporting them when this had been required.

Medicines were held securely. Senior staff carried out regular audits of medicines to check that staff had signed for medicines administered and a check of stock to ensure that people had received their medicines as prescribed. Staff who handled medicines had been provided with training. People were satisfied with staff handling their medicines. Staff maintained appropriate records of administration. Where there were medicines administration or recording errors, there was a system in place to identify these and action taken to address performance issues with staff. This assured us that systems were in place and steps had been taken to identify and respond to medicines administration errors.

The provider's recruitment procedures demonstrated that they operated a safe and effective recruitment system. This included completion of an application form which identified any gaps in employment history. The process also involved a formal interview, previous employer references obtained, identification and criminal records checks. People who used the service had been involved in interviewing candidates. This they told us helped them feel important and valued. People could be assured action had been taken to check that newly appointed staff had the necessary skills and had been assessed as safe to provide their care and support.

Requires Improvement

Is the service effective?

Our findings

Staff told us that the majority of the training they received was delivered through an on-line, e-learning facility. They also told us that other training such as moving and handling, epilepsy and autism awareness was provided face to face by a trainer within a group setting which they preferred as a learning environment.

When asked their views about the suitability and competence of staff relatives told us, "I think they are well trained" and "My [relative] is fairly happy there but I do think their training in autism awareness is lacking. They have little awareness about the spectrum of autism and this shows in their understanding of people."

The provider had a policy that supervision support meetings should be provided for staff on a monthly basis. Staff received opportunities for access to staff meetings on occasion. We noted from a review of documents and from discussions with staff that there was a system in place to ensure planning for staff supervisions. However, in practice supervision did not always take place as planned. Staff told us that supervision was provided sporadically. Management audits had also identified that opportunities for staff to receive one to one supervision meetings were 'severely overdue'. This meant that staff had not regularly been provided with opportunities in accordance with the provider's policy. This meant opportunities were not always readily available for them to discuss their work performance and plan for their training and development needs and set objectives to achieve these.

People and their relative's told us that care staff understood people's rights and the principles of obtaining consent before the delivery of care and support. People told us care staff always asked for their consent before they support them. Care staff told us they had received training in understanding the Mental Capacity Act (MCA) 2005 via on line e-learning methods. However, our discussions with the staff and management demonstrated that there was limited understanding of their responsibilities in relation to the MCA and what actions they should take if they identified anyone who may have their freedom of movement restricted. For example, where risk assessments had highlighted a risk of a person running into the road and climbing out of windows. There was insufficient guidance for staff in managing these situations or recognition of the potential to restrict this person's movements where there was a possible need to use restraint in the person's best interest to keep them safe from harm.

Care and support plans recorded people's specific dietary requirements, preferences and any food allergies. People's care plans recorded any support they required with encouraging a healthy diet. The availability of staffing had impacted on occasions staff ability to support people with preparing fresh food. Staff had completed training in relation to food hygiene and safety. Relative's told us that they did not always feel that staff paid sufficient attention to supporting people to maintain a healthy diet and one expressed concern that their relative had gained too much weight. People told us that when there was insufficient staff available to cook with them on a one to one basis they would often go to the fast food outlet to purchase food. This had the potential to put their health at risk.

People were supported to access a range of health and wellbeing services. Daily records evidenced that staff recognised changes in people's needs in a timely way and promptly sought advice from health professionals

when required. People told us they had access to support from their GP and health screening services. We saw from a review of records such as diaries, handover and daily log records the planning and support of people to attend health care appointments, opticians, dentists, podiatrists and occupational therapy assessments.

Staff had implemented a document known as a 'health passport' which contained information which was easily accessible and available to accompany anyone who required emergency admission to hospital. This meant that important information about each person would be communicated to healthcare professionals when required.

Good

Is the service caring?

Our findings

People and their relatives told us staff were caring and compassionate and treated them with respect for how they wished to live their lives. People told us they had good relationship with the staff who supported them and enjoyed their company. Relatives said staff were friendly and respectful in their approach and that staff treated people with respect. One relative told us, "There are some staff who work better with [relative] than others and understand their needs and can relate to them in a way that others appear not to be able to, but that could be a personality thing."

When we asked people to describe how staff spoke to them one person told us, "They always talk to you adult to adult, with respect for you as a person." Another told us, "They talk to me nicely."

People were observed to have their right to privacy respected. People told us their flats were their private spaces where they could be alone when they chose and this was respected. Staff were observed to treat people with dignity by talking to them in a polite manner, listening to them, responding and affirming them in a way that enabled and encouraged them to know they had been understood.

Care staff had developed trusting relationships with people and spoke with insight about people's needs and the challenges they encountered. They were able to tell us about people's histories and their personal preferences with regards to the way they wished to be addressed, how they liked to spend their time and the level of support they required whilst encouraging people to maintain as much independence as possible.

People told us they had been involved in making decisions in the planning of their care. They also told us the registered manager showed them kindness and compassion and that staff listened to them if they had any worries or concerns and responded appropriately. For example, one person told us, "The staff are good to me. This is my home. Yes, they are kind and we have a laugh sometimes. If I am worried about anything there are staff I know I can talk to." Another told us, "I have my favourites, those staff who listen to me and I am comfortable with. I like living here it's the best place I have lived."

People's preferences had been assessed and recorded within their care and support plans. Support plans included information where the person had been given the opportunity to express things and people that were important to them. Staff supported people to express their goals, aspirations and plan towards achieving them. For example, one person told us, "They encourage you to think that you can do things for yourself and they encourage you to be independent."

Requires Improvement

Is the service responsive?

Our findings

Information was available on notice boards to inform people of how to make complaints should they wish to do so and available in an easy read, pictorial format. People and their relatives told us they would not hesitate to speak with any of the staff and the management of the service should they have any concerns or complaints. We saw the provider had a complaints policy and process in place for managing complaints. When asked to view a log of all complaints received in the last year. We were shown a folder which contained some complaints received from people who used the service about other people also using the service. However, we noted from discussions with relatives who told us they had lodged formal complaints and a review of management audits which described complaints that had been received from relatives and social workers that not all complaints received had been logged in accordance with the provider's policy. This meant that the complaints we became aware of had not been logged in accordance with the provider's policy on handling complaints. The provider did not operate an effective system and process to ensure there was a clear audit trail which logged complaints efficiently and described how people's complaints had been responded to with outcomes and actions taken in response to these complaints.

This demonstrated a breach of Regulation 16(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had a support plan which was personalised and reflected people's personal choices and preferences regarding how they wished to live their daily lives. Support plans were reviewed and reflected people's changing needs. People's care plans included personal profiles which described; 'How you can support me', 'My life picture', 'My strengths, wants and needs'. The provider told us that care plans belonged to people and each person had a copy of their care plans within their flat. We found that care plan folders contained comprehensive information but were bulky with out of date documents and were not always recorded in a personalised format that the individuals using the service could understand and access.

Senior manager's audits identified when care plans were in need of review and updating to reflect people current care and support needs. Staff were kept aware of any changes in people's needs on a daily basis. Daily records contained information about what people had done during the day and any changes in their health and care needs. There were verbal handovers between shifts, when staff teams changed, and a communication book to reflect current issues. These measures helped to ensure staff were aware of and could respond appropriately to people's changing needs.

People had been allocated a package of care with a specified number of hours allocated to staff to provide one to one care support. Not all care plans recorded a breakdown of the hours allocated with a plan of the care and support to be provided within those hours allocated. People told us they were not provided with a weekly schedule which would provide them with information as to the staff who would be allocated on a weekly basis to support them. One person said, "I don't always know who is coming to help me. I would like to know who. It is important for me to know who is coming to see me." Another told us, "I don't always know who is coming to help me. I would like to know which staff are coming this would help me feel prepared."

We asked the manager how new or agency staff would be able to obtain a pen picture of each person's care and support needs when allocated to them with easy identification of risk and actions to guide these staff. They told us that these staff would be expected to read the whole care plan which they also agreed would take some time to do so. We discussed with the manager the potential to put people at risk of not having their care and support needs being met without an easily accessible, pen picture of a person describing any risks and how they wished to be supported.

People views were sought on a daily basis when staff supported people with their care and support needs. However, there was little evidence of any formal systems other than annual care reviews carried out by the local authority that the views of people were regularly sought which would support effective planning for continuous improvement of the service. We noted that the regularity of opportunities for people to be involved in a 'Person Centred Reviews' which would include their involvement in the review of their care plan and to be enabled to feedback their views regarding the quality of care were sporadic and did not take place as regularly in accordance with the provider's policy. We noted from records reviewed that people's care reviews had been cancelled on recent occasions due to insufficient staff available to conduct these. Tenants meetings were also found to be irregular. People and their relatives told us that the provider could improve in providing more opportunities for them to be able to express their views on a regular basis. One relative told us, "The current ad hoc approach to listening to people does not enable them to feel valued and their opinions important."

People were protected from social isolation because they were supported and their relatives told us that people were supported to follow their own hobbies, interests and received support with opportunities to access further education at college, day services and community activities. On the day of our visit we saw people supported to go out to visit relatives, shopping and access to college.

Requires Improvement

Is the service well-led?

Our findings

It was evident during our inspection that the service was not being managed on a day to day basis from the registered location, Stable House in Colchester but was being run from Norwich Road in Ipswich where the manager and staff were based. This was also the location which was the point of contact for people who used the service. Following our inspection we asked the provider to explain why the Norwich Road should not be registered as a separate location to clarify the services registration and provide an up to date statement of purpose to ensure that the registration correctly reflected the regulated activities.

People in the main told us they were satisfied with the service apart from when shortages of staff prevented them from receiving the full allocation of their hours designated for their one to one support. People told us they found the manager approachable and described them as, "Kind", "Helpful" and "Will sort things out for you when you need them to." It was evident from some of our discussions with people that staff discussed with people who used the service their disgruntlement with the leadership of the service. This impacted on people's ability to feel secure about the environment within which they lived.

All staff we spoke with told us they enjoyed their work and found the manager approachable. However, they also told us the morale of staff was of concern. It was evident there was a culture of discontent with regards to management of the rotas, previous management of alleged staff misconduct and disunity within the staff team.

Relatives when asked for their views about the culture of the service told us, "I like the manager they are a lovely person but they have a lot to learn about managing people and could do with toughening up a bit. There is not a good atmosphere there when you visit. Staff are bickering amongst themselves and we get to hear about it." Another relative told us, "I am more than happy to go to the manager when concerned about things but I am not very happy about the standard of care at the moment. The place is going downhill. There is division amongst the staff, rotas are not managed properly and there are some staff who are constantly complaining and not always appropriately."

We noted from a review of messages recorded in staff communication books that these on occasions demonstrated a culture of negativity and finger pointing. Discussions with staff further evidenced a culture amongst the staff team which did not evidence the promotion of a positive enabling atmosphere which prioritised the wellbeing of people using the service. Discussions with people and their relative's showed us that there was a blurring of personal and professional boundaries amongst staff. People and their relatives told us of staff complaints to them about other staff and disgruntlement at the management of the service which had been openly expressed to them. We discussed this with the senior management of the service and were reassured that action was being taken to identify issues and action planned to improve the culture of the service.

A range of management audits to assess the quality and safety of the service were regularly carried out. These audits included a review of care planning, medicines management monitoring and health and safety checks. Environmental risk assessments were in place and regularly reviewed. Accidents and incidents were

logged and analysed. Findings from these were cascaded up to senior management for analysis and review. Where shortfalls had been identified audits contained timescales for actions to be completed and follow up.

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
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not operate effectively an accessible system for identifying receiving, handling and responding to complaints.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure sufficient numbers of suitably qualified staff were available at all times to provide people with the one to one care support allocated to them. They did not keep a log for analysis to evidence for assessing impact and planning for improvement.