

# Care Management Group Limited

## Uxbridge Road

### Inspection report

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### Ratings

Overall rating for this service	Good ●
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Is the service safe?	<b>Requires Improvement</b> ●
Is the service effective?	<b>Good</b> ●
Is the service caring?	<b>Good</b> ●
Is the service responsive?	<b>Good</b> ●
Is the service well-led?	<b>Good</b> ●

# Summary of findings

## Overall summary

We undertook an announced inspection on 28 and 29 June 2016. The last inspection of the service was in March 2014 when we found the provider was meeting all of the standards we inspected.

Uxbridge Road is a supported living service providing various levels of personal care support to nine adults who have a range of needs, including learning disabilities, mental health needs and physical needs. There is a main house where seven people lived and an annexe in the garden where two people lived. People lived in individual flats (which comprised a bedroom and en-suite facilities) and there were shared communal areas, for example the kitchen and living room which people could use. People had a tenancy agreement and rented their accommodation. The support hours varied from a few hours per day to one to one support during the whole day. This was dependant on people's individual needs. The service was staffed 24 hours a day. There were eight people using the service at the time of the inspection as one person was in hospital.

The registered manager had left in February 2016 and the deputy manager, now the acting manager, was in the process of applying to become the 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.

Individual risk management plans were in place and staff were aware of the content and this informed their practice to enable them to support people appropriately. Those records that required clarifying were reviewed and updated during the inspection.

Improvements were being made to the monitoring of the service. Audits were recorded and included the various areas relevant to the service, such as checking staff recruitment information and the details in people's care records.

People using the service told us they felt safe and we saw there were systems and processes in place to protect people from the risk of harm.

People told us that they were involved in their assessment of their needs and were encouraged to be involved in decisions about their care to ensure they received the support the way they liked.

People's individuality and diversity was taken into account. People were supported to access their local community, take part in social and recreational and activities of their choice. People were supported to build and maintain social relationships so they led fulfilling lives and there were sufficient numbers of staff working to enable them to help people achieve this.

The Mental Capacity Act (2005) had been appropriately applied and the best interest decision making process followed to ensure decisions about people's care were made collectively by more than one person.

Recruitment and selection procedures were in place and checks had been undertaken before staff began work.

Staff told us that they had access to training and were supported by the acting manager to undertake their role.

Arrangements were in place for the management of medicines and staff had been trained and assessed as competent in medicines administration.

People had access to the relevant health care services when needed to ensure their healthcare needs were met.

People's views and complaints were listened to, addressed in a timely manner and used to improve the service.

The acting manager made them self available to people who used the service and the staff team. Staff were positive about the management in the service.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

There were some aspects of this service which were not always safe.

The risk management plans associated with people's support were assessed and reviewed but needed to clearly show if there was a risk to ensure information was accurate and relevant to the person.

People using the service told us they felt safe. Staff were knowledgeable about how to recognise signs of potential abuse and aware of the reporting procedures.

The provider carried out checks to make sure staff were suitable to work with people using the service, although audits needed to take place on these files to ensure all information was obtained and recorded.

There were enough staff to meet people's needs.

Safe arrangements were in place for the management of medicines and staff had been trained and assessed as competent in medicines administration.

**Requires Improvement** 

### Is the service effective?

**Good** 

The service was effective.

People received individualised care that met their needs.

Staff were skilled and knowledgeable for their roles, and received appropriate support through supervision meetings and appraisal of their work.

The management and staff had a clear understanding of the Mental Capacity Act 2005 and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected.

People were supported with their food and drink to maintain a balanced diet.

Access to relevant healthcare services ensured people's healthcare needs were met.

### Is the service caring?

Good ●

The service was caring.

People received support in a caring a compassionate manner.

Staff encouraged people to be independent and people were able to make choices and have control over the care and support they received.

People's right to privacy and dignity was respected.

### Is the service responsive?

Good ●

The service was responsive.

People were involved in the assessment of their care needs and were supported to maintain links with their local community.

People took part in meaningful activities and were encouraged to build and maintain links with the local community.

People knew how to complain if they needed to and they were confident that their concerns would be addressed.

### Is the service well-led?

Good ●

The service was well led.

The provider put arrangements in place to effectively monitor the quality of the service and made improvements during our inspection.

The acting manager was visible and inclusive and wanted to provide a good quality of life for the people using the service.

# Uxbridge Road

## **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 28 and 29 June 2016 and was unannounced.

Before the inspection we looked at all the information we had about the service. This information included the statutory notifications that the provider had sent to the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us.

Prior to 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.

The inspection was carried out by a single inspector.

We met with the acting and deputy manager, two support workers, a social care professional, one relative and five people who use the service.

We looked at the care records for two people living in the service, six staff employment and training files, checked two people's medicines and viewed records relating to the management of the service, including audits carried out on different areas of the service.

We also requested feedback from two social care professionals via email, however, on this occasion we did not receive their responses.

# Is the service safe?

## Our findings

We looked at the safety of the building. The acting manager informed us that only one window restrictor had been fitted to an upstairs room due to potential risks. One person told us they had a window restrictor in their room and they said they knew why this had to be fitted but that their room did get warm at times and they had to keep their door open to let air flow in. The acting manager confirmed via an email four days after the inspection that risks had been assessed for each person to ensure that if they needed a window restrictor then one would be fitted. The acting manager also stated that restrictors had been requested and if people agreed even if the risk was minimal then these would be fitted.

There was a bed rail risk assessment in place for one person. This person also had a risk management plan which evidenced how to support the person and evidenced the risks associated with pressure ulcers. This person also had a specialist profiling bed and mattress which further reduced the risk of pressure ulcers.

A finance risk management plan for one person had not been updated and did not reflect the person's current needs, as it stated they signed when financial transactions had taken place, however their support plan clearly recorded that they could no longer sign documents. We were informed the second day after the inspection that this had been updated.

In one person's file there were minutes from a meeting held in 2015 which various professionals had attended and it was stated that the person could be at risk of choking. However, the speech and language therapist (SALT) had visited a few months after the meeting stating the person was not at risk of choking. This was documented on the person's support plan with a clear 'no' recorded in response to the question 'Is the person at risk of choking.' The acting manager confirmed that they would reference the SALT assessment findings in this support plan as it did conflict with what the professionals meeting had decided.

People's files contained risk assessments relevant to other aspects of their lives. The assessments covered possible risks, such as self-harm, self-neglect and managing finances. Risk assessments included guidance for staff on how to mitigate identified risks. Personal evacuation emergency plans (known as PEEPS) were also in place. These documents had been evaluated and reviewed to make sure they were current and remained relevant to the person using the service.

People told us they felt safe living in the service. One person said "I would go to my keyworker (a named member of staff) if I was unhappy or worried." Another person told us, "I feel safe here." There was information on recognising abuse and reporting it in the main communal area of the service. We saw people had the chance to talk about any concerns such as safeguarding concerns during the meetings held for people.

Staff we spoke with confirmed they had received training on safeguarding people. They knew to report concerns to the acting manager and if they needed to they were aware of also informing the Care Quality Commission (CQC) and the local authority. There were procedures on safeguarding. Copies of these were available for staff and all new staff were required to read these and confirm their understanding of the

procedures to ensure they knew what action to take if they suspected a person was at risk of harm.

Records were kept of any safeguarding concerns raised, along with details of action taken. We saw that the information had not been kept all together. The acting manager explained that the reason for this was that confidential safeguarding information was securely stored to ensure access was restricted.

Incidents of when people expressed themselves in particular ways that might affect them or others were recorded. This included the steps taken to minimise risks and provided details of how to diffuse certain situations. We saw some recent completed body maps where staff had noted areas needed to be highlighted to staff and the acting manager. For example, one June 2016 body map which noted a potential issue with a person had not been checked or signed by the acting manager and they said they had not seen some of the body map records where there was no evidence of input from the acting manager. They informed us that staff would be reminded to make these forms available to them so that they could act on anything requiring attention.

We saw various checks on fire safety were in place. Fire drills were held quarterly, with the last one held in May 2016, but these had not taken place with any night staff. The acting manager confirmed that this would be arranged to ensure all staff attended a fire drill practice. The fire risk assessment had been reviewed in June 2016 with action points that the acting manager confirmed were being addressed. Fire equipment had been serviced and the acting manager was introducing daily fire checks from the 1 July 2016. Other servicing checks were in place on the equipment people used on a daily basis, such as the portable appliance tests, which was checked April 2016. Gas safety checks had also been carried out in September 2015.

People said there were staff available to talk with. One person told us, "I can talk with staff whenever I need to." Another person confirmed, "Got all the staff around here, there is always enough staff." We viewed the staff rota for June and July 2016 and saw that staff did not work too many days and shifts without taking a break. Two people received one to one support during the day and if they were admitted into hospital then staff would be allocated to stay with the person and support them in hospital. There were some people who could go out without staff support and where they required staff to assist them to engage in activities or receive personal care we saw that this was provided. We saw no-one having to wait for staff to assist them and staff confirmed there were sufficient numbers of staff working on a shift.

There had been staff changes in the past few months and there were outstanding staff vacancies. The vacant shifts were filled by staff working overtime, which the acting manager monitored or through using bank staff who were familiar with people's needs. Occasionally agency staff were used and the acting manager confirmed they requested a summary of any agency person to ensure they were suitable to work with the people using the service. The acting manager described how some new staff did not have any previous experience in care work but that the staff team had a mixture of skills and knowledge from a range of employment or caring duties staff had carried out.

We viewed staff recruitment files. Staff confirmed they had been interviewed and provided the necessary documentation to work in the service. Applicants had to complete a numeracy and literacy test. The acting manager told us that people using the service were encouraged to participate in the interviews for new staff so that they could ask questions and be a part of deciding who would be working in the service.

Various documents were on each staff member's file. We were informed that the provider no longer used application forms and that applicant's applied giving information on their background and provided their Curriculum Vitae (CV) and details of references. There was one unexplained gap on one staff member's CV



from August 2015 up to the point of applying for the post and being interviewed early in 2016. The written interview notes in the staff file confirmed this gap had been explored at interview and the acting manager confirmed shortly after the inspection that this had been verified and recorded. We were told that the gap had been a short period of employment but there was no employment reference for this staff member, only character references. The acting manager said they would look at obtaining this additional reference. On a second staff file there was no disclosure and barring service (DBS) number. The acting manager confirmed following on from the inspection that this was obtained from the staff member and recorded on their file. We were informed that this information was also held centrally in the human resources department. Proof of identification and address were on the recruitment files we looked at.

Medicines were being stored securely at the service. Some people looked after their own medicines whilst others due to their individual needs required staff to store and administer their medicines to them. One person said "staff help me with my medicines," whilst another person told us, "I know the medicines I am on and they keep me well." Each person had a medicine profile form which included their photo, details of any allergies, a list of their prescribed medicines, the reason for taking the medicine and their side effects. There were clear guidelines regarding how the person liked or needed to receive their medicines, with one form noting that the person did not "have a preference for who gives me my medicines." There was also a medicine risk management plan which we saw for one person. This highlighted the identified risks and support they needed.

Two staff signed the medicine administration record sheets (MARS) once a medicine was administered. We checked two people's medicines. We checked the quantity of boxed medicines stored in the medicine cupboards for one person and we saw that these tallied with the balances recorded on their MARS. There were some issues with the amount and recording of paracetamol for two other people which did not tally with the amount noted on the MARS. We checked the previous MARS and saw where the errors had occurred and that people had not missed out on when they had needed their medicines. The acting manager and deputy manager confirmed the MARS would be amended to ensure the correct amount was recorded and that all medicines would be counted daily as the medicines given as and when required (PRN) had not been counted on a daily basis.

We saw that there was a shift leader daily medicine check record so that staff handing over could verify medicines had all been administered correctly and recorded. Previously there had also been monthly medicine counts completed by the acting manager but these had recently changed to weekly to ensure they were closely monitoring medicine management in the service. An audit by an external pharmacist had also taken place in September 2015 to ensure staff were following good practice and safely meeting people's needs.

## Is the service effective?

### Our findings

Staff felt supported and told us they received one to one supervisions. Records we saw confirmed this. The acting manager said they regularly met informally new staff as well to ensure they were settling in and did not have any queries. Staff confirmed they had received an induction to the service. This included in house to become familiar with the service, a corporate provider induction and shadowing experienced staff. We saw new staff who confirmed they were observing and were shadowing staff to get to know people's needs. New staff also completed the modules aligned with the Care Certificate, (these were a set of introductory standards that health and social care workers adhere to in their daily working life to provide compassionate, safe and high quality care and support).

Staff received both face to face and online training. Staff only administered medicines once they had received training and were deemed competent to carry this out independently. Once a year staff were assessed on their ability to continue to carry out this task appropriately. Other training courses included, first aid, autism awareness and mental capacity act training. Moving and handling training was provided in house and was specific to the needs of the people living in the service. New staff were due to attend this training and the acting manager was arranging for this to ensure all staff could carry out this task safely. There was no evidence of which staff members had received specialist training to support one person using the service. The deputy manager provided a list of staff who had last received this type of training but confirmed certificates were not given out by the nurses who provided this to staff. This particular training session had been booked for new staff on the 8 July 2016 to ensure all staff could meet the person's needs.

To ensure staff worked with people effectively they received training in positive behaviour support (PBS). PBS is an approach to support people learn new skills to cope with everyday life and manage their feelings and emotions. It informs staff to be proactive rather reactive towards people who might express themselves in particular ways that could harm themselves and/or others.

All staff training was recorded so that the acting manager could monitor who needed to attend or complete training. We saw a sample of these individual training records and certificates which showed the percentage staff received with their online training and when mandatory training was due to expire.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for community services would be via the local authority and Court of Protection. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Three people using the service went out safely in the community alone and unsupervised, whilst others

required staff support and assistance to ensure they could safely access community facilities. The acting manager provided evidence to show that applications had been submitted to the Court of Protection where relevant for people and they were waiting to hear an outcome of the request for assessments. Therefore we saw no evidence that people were being unlawfully deprived of their liberty.

Where possible, people using the service had been involved in planning the support they needed and had signed to demonstrate they had given consent to their support plan. Staff confirmed they encouraged people to make their own daily choices about their lives. One staff member told us they worked "in people's best interests." People were also involved in other ways in relation to the support they received such as attending meetings with their keyworker or meeting with other professionals. We saw on the second day of the inspection that a social care professional was visiting the service to make sure everyone involved in a person's life had considered if they had capacity to understand their tenancy and make decisions about their lives. Where necessary, other professionals were involved to support the person and to ensure they were appropriately supported in the service.

People were given the support they needed to meet their nutritional needs. Wherever possible people did their own food shopping and prepared and cooked meals with staff assisting them. Some people required more help than others. People told us, "I enjoy cooking," whilst another person said, "I can cook but I don't always." If people wanted to they followed a menu plan to help them aim to eat a balanced diet. Staff recorded what people ate and those people who required closer monitoring of their food and fluid intake then staff recorded this so that any problems could be checked and responded to swiftly. In one person's care documents it was stated that they would ask to have a drink in between eating their meal. We observed that staff offered the person a drink in between eating their lunch which followed the person's preferences.

People's health needs were recorded on their care documents and described individual health conditions and the support people needed with these. One person confirmed that they went, "on their own to health appointments." People with learning disabilities often have unmet physical healthcare needs therefore Health Action Plans (HAPs) were introduced by the Department of Health. HAPs hold information about people's health needs, the professionals who support those needs, and people's various appointment. People at the service were supported to maintain good health and had access to other healthcare professionals such as the GP, opticians and dentists. HAPs contained information about people's individual health needs together with a clear description of any support required.

## Is the service caring?

### Our findings

Comments from people using the service on the staff team were complimentary. They included, "they (staff) are there for anything we might want," "staff help me feel more in control of my life," "this feels like home," and "my keyworker has inspired me to do things." A relative confirmed that staff were "friendly and helpful." They also stated that their family member had "thrived since living in the service."

People were encouraged to maintain social relationships with family and/or friends. One person told us, "I get the train to visit my family," whilst another person said, "I see my family a lot."

People told us they were supported to be independent. They confirmed they had a key to their bedrooms, which they showed to us and that they always kept these rooms locked. One person told us, "Staff respect me if I want to be alone".

Gender care preferences were noted on people's files so that people felt comfortable when receiving personal care.

We saw staff understood people's individual needs and limitations and communicated with them in an empathetic and appropriate manner. Staff responded to people when they asked them questions and diverted people where necessary in order to ensure people were calm and felt listened to.

People who were not always able to communicate verbally were supported by staff who understood their specific methods of communicating. Staff could describe how they observed people's body language and the sounds they made to see if they were happy or needed assistance. They acknowledged that sometimes they had to figure out what a person was feeling if they could not verbally express themselves. Staff said this could take time and the more you got to know the people using the service and all the different ways they communicated the more you understood what they were telling staff.

The atmosphere in the service was pleasant. There was chatting and appropriate use of humour throughout the inspection. We saw positive interactions with all the people using the service. Staff readily engaged with people and made sure they were comfortable.

The acting manager informed us that people did not have an independent advocate as they had family members to support them and help them with decisions about their lives.

## Is the service responsive?

### Our findings

People's care and support had been assessed before they started using the service. One person confirmed they had visited the service and said they "decided to stay." Assessments we viewed had gathered information about the person and their individual needs prior to them moving into the service. As this was a supported living service, in people's files we could see a letter from the new housing provider with a tenancy agreement. People also received a tenancy handbook outlining the services they could expect to receive and the rules people had to follow in order for them to maintain their tenancy.

Information in the support plans were person centred and focused on people's preferences and abilities. Personal details that staff would need to know were recorded, such as "I like to wear thick socks" and records detailed that a person liked to wear perfume. Other routines for example that a person liked a cup of tea in the morning provided staff with the details that mattered to the people using the service. There was evidence that people had been involved in discussions about their care, support and any risks that were involved in helping the person live their lives.

Staff worked closely with people and their families in developing and reviewing people's support plans so care and support was provided in line with their wishes. Staff spoke about people confidently, were knowledgeable about people's individual needs, which enabled them to provide a personalised service.

The acting manager informed us that they had introduced a matching form for people using the service to express the type of keyworker they wanted to support them and meet with. The form encouraged people to say what shared common interests the staff member should have and the skills. This was to help people be part of choosing who they met with on a regular basis and who they could develop a good working relationship with. People met with their keyworkers every month, if they agreed to these meetings to talk through any concerns and to look at their needs and see how they were progressing in their lives.

People took part in a range of activities both with staff support and alone if they were able to go out without assistance. People said, "I go to the gym," whilst another said, "I like cycling and I help out at the church." People, if they wanted one, had an activity plan which highlighted the interests they had so that staff were aware of how to stimulate people. One person described the holidays they had been on and the future ones planned. They confirmed they enjoyed going away with staff support.

People told us they knew how to make a complaint and that staff listened to them if they expressed any concerns. A relative said their family member would tell them if they were unhappy about something. The relative told us "I have no concerns."

A record was kept of the complaints received. The service had a large book where compliments and complaints were recorded. The acting manager also recorded online the complaint along with any responses and outcome to a complaint. Details of making a complaint were in the tenant's handbook but although we were told it was also on the communal notice board to ensure it was visible for everyone we did not see this. The acting manager confirmed this would be checked and made available for people.

Where requested or identified as a need staff met with relatives on a regular basis to ensure they had time to ask questions about their family member and to hear any updates from staff. This in particular was working well where relatives had wanted clearer and more regular communication with staff. Where people agreed relatives were also invited to annual review meetings and a relative confirmed their family member attended as they lived nearer to the service.

## Is the service well-led?

### Our findings

Although we identified there was some missing information on one of the staff files audited, the inspection found that the quality assurance and monitoring checks had been effective with clear improvement plans in place. The regional director also checked a sample of staff files as part of quarterly and monthly audits.

On two care files for people there was some information that did not show if it had been reviewed and some documents had not been updated. There was evidence of the regional director completing a quality audit in January 2016 and evidence of the provider's quality officer supporting the acting manager with updating care files and meeting the actions previously identified in this audit. There was also evidence of a mock inspection carried out by an external consultant in May 2016 with an action plan to make improvements. The action plan from this mock inspection was being addressed as quickly as possible and progress was checked regularly by senior managers.

We were told that people's care records were checked by the acting manager but that these audits had not been recorded which the acting manager confirmed they would do following on from the inspection. Finally as the medicines that were only given as and when required (PRN) had not been counted on a daily basis we had found some issues with the accurate recording of these medicines for two people. The medicine audit carried out the week before had not picked up on this problem, however the acting and deputy manager confirmed these would also be counted daily to ensure records were maintained correctly.

There were systems in place to monitor the service and to ensure that any areas needing to be addressed were swiftly acted on. For example, incidents were recorded so that the acting and deputy manager could respond to particular patterns. The acting manager explained that it had been identified that during the changeover of staff in the afternoon there had been an increase in incidents and events occurring. Therefore, there were now always staff around during the handover meeting which the shift leader attended, to ensure people were supported and had staff to talk with. We saw staff members were available during the inspection at the handover time.

We saw a health and safety check had been carried out in May 2016 which had looked at various aspects of the environment. An easy read version was also produced for people who understood a plain English simpler version. Infection control was checked monthly with staff and people using the service involved, which was available in a pictorial format.

There were quality visits from the regional director and the last one carried out was in January 2016. There was also a visit by the quality support officer in April 2016. All of these audits and visits had generated actions to complete. The acting manager confirmed that he had met many of the actions identified and he was completing the remainder. The visits included checks on people's care records, training for staff and infection control.

The acting manager showed us the monthly reports they had to complete which looked at different aspects of the service. This included, what audits had been carried out and staff support, such as appraisals that had

taken place.

There were various ways to gain the views of others and the provider had a system in place for relatives from other services to visit this service. They did not look at records but talked with staff and people using the service and carried out observations of interactions. The last visit had been in May 2015.

Satisfaction surveys were given to people using the service, relatives, professionals and staff. We saw the results for the staff surveys but no other results or analysis from the previous manager. There had been on two of the 2015 relative surveys some comments which should have been identified and responded to which we could not see had been addressed. The acting manager confirmed that 2016 satisfaction surveys would be sent out and that they would look through the completed surveys once back and ensure there was a response and action plan should any negative comments or room for improvement be noted.

The acting manager, who had previously been the deputy manager had been in post a few weeks and was familiar with how the service operated. They confirmed they were studying for a National Vocational Qualification (NVQ) level 5 in care and had a diploma in positive behaviour support (PBS). They confirmed they kept up to date with current good practice through meeting other managers working in different care settings and received support through these meetings and by their line manager.

Staff gave positive feedback about working in the service and on the management support in the service. One staff member told us, "there is good teamwork." Another said they "try their best" and that there had been "huge improvements" to the service and that the management know what needs attention. Staff also confirmed that overall there was good communication and that they could talk with the deputy or acting manager if they needed to. Messages were passed through daily handover meetings, communication book and the daily diary. Meetings were held for staff every month with the last one held in June 2016. The acting manager confirmed that each month topics were to be discussed. This included, health and safety and complaints.