Creative Support Limited

Creative Support - Bolton Service

Inspection report

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Ratings

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

Overall summary

This was an announced inspection carried out on the 09 and 15 December 2015.

Creative Support - Bolton provides care and support for adults who are living with autism and with mental health illnesses. The office is situated in Bolton town centre and the houses are located in the Bolton area.

There was a registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered 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 branch manager has been registered with the Care Quality Commission for several years.

At the last inspection carried out in July 2013. At that inspection we found the service was meeting all the regulations we reviewed.

Summary of findings

As part of the inspection we attended a family forum meeting on the evening of 09 December 2015. These meetings were organised by the registered manager and provided families of people using the service with the opportunity to meet up for refreshments and discussion about the service and other items of interest.

We found medicines were managed safely. However, we have made a recommendation for the service to consider current guidance on managing minor ailments.

We looked at care files to understand how the service delivered personalised care that was responsive to people's needs. We found that initial assessments were undertaken to determine the needs of people. Care file records contained people's life story details and considered issues such as communication and behaviour.

We found the service had systems in place to deal with and respond to concerns and complaints. The relatives spoken with knew how to make a complaint, however some felt their concerns were listened to but not always acted on.

Staff spoken with had an understanding of the whistleblowing procedures. Staff had contacted the CQC and raised some concerns about a serious allegation and concerns over staffing levels and skill mix. This was dealt with by a multidisciplinary team meeting and suitable actions were taken by the provider.

We saw that staff had undertaken training in Mental Capacity Act 2005(MCA) and Deprivation of Liberty Safeguards (DoLS). These provide legal safeguards for people who may be unable to make their own decisions.

Systems and procedures for the recruitment of staff were safe and robust. This was evidenced through employment our examination of employment files. Disclosure and Barring Service (DBS) checks had also been completed to ensure the applicant's suitability to work with vulnerable people.

Staff received training and development to ensure they were fully supported and qualified to undertake their roles. Supervision sessions were completed on a regular basis and records were maintained.

We found the service had systems in place to monitor and assess the quality of the service delivery.

Providers are required by law to notify CQC of certain events in the service such as serious injuries, deaths and safeguarding concerns. Records we looked at confirmed that CQC had received all the required notifications in a timely way from the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The safe was not consistently safe.

Staffing levels and the staff mix did not always protect people using the service. Staff had received training in safeguarding vulnerable people from abuse. However staff did not always follow the correct procedures.

Not all people received their medicines a timely manner.

Risk assessments were in place for the safety of the premises. The homes inspected were cleaned and well maintained.

Requires improvement

Is the service effective?
The service was not consistently effective.

People were not always helped to select their food preferences. Families' wishes were not always acted upon.

Staff completed a four day induction programme on commencing work at the service and further training was on-going.

Care records were detailed and provided staff with guidance of how care was to be provided.

Requires improvement

Is the service caring?
The service was not consistently caring.

Staff spoken with had a good understanding of the care of people and could describe what good care was.

Some staff were described as great and friendly; others were seen to be less sympathetic.

People's personal care was not always delivered in line with care preferences.

Requires improvement

Is the service responsive?
Not all aspects of the service were responsive.

Some people we spoke with and their relatives felt that the care and support they received was not always responsive to their individual needs.

Procedures were in place for receiving, handling and responding to concerns and complaints.

Requires improvement

Summary of findings

Activities outside the home were good; however these were limited inside the home.

Is the service well-led?

Not all aspects of the service were well-led.

It was not clear if the registered manager had been made aware of some of the concerns raised and the action of some of the staff.

Some staff did not feel listened to and supported by the management.

Systems were in place to monitor and assess the quality of the service.

Requires improvement

Creative Support - Bolton Service

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008, as part of our regulatory functions. This inspection checked whether the provider 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.

Before the inspection we reviewed information we held about the service. We reviewed statutory notifications and safeguarding referrals. We also liaised with external professionals including the local authority, local commissioning teams and the safeguarding team. We also reviewed previous inspection reports and other information we held about the service. Prior to our inspection to the service, we were provided with a copy of a completed provider information return (PIR); this is an document that asked the provider to give us some key information about the service, what the service does well and any improvements they are planning to make.

This inspection took place on 09 and 15 December 2015 and was announced. We provided notice of the inspection to ensure management were available at their Bolton office to facilitate our inspection. We met with the registered manager on 09 December 2015. The registered manager was unavailable on the 15 December 2015; however, the service director assisted us with the second day of the inspection. The service was providing care to 14 people living with autism in four houses, seven people living with mental health illnesses in two houses and nine people living in supported flats with staff on duty 9.00 – 17.00 and a member of staff on a sleep in shift.

We also contacted six relatives of the people living some of the homes to obtain their views of the services provided. The inspection was carried out by one adult social care inspector.

As part of the inspection, we spent time at the local office, we looked at records including three care plans, medication administrative records, three staff personnel files, supervision records and service policies. We also visited four of the houses and spoke with eight staff.

Requires improvement

Is the service safe?

Our findings

As part of the inspection we visited four of the houses. The people who lived in the houses we visited had tenancy agreements and were supported by staff twenty four hours a day. Some people living in the houses had limited means of communication and were unable to tell us if they felt safe and were happy with the service and level of care they received. People living in the houses relied on their families acting on their behalf to make decisions for them and on the care and compassion of the staff that cared for them.

One parent told us that, "Most of the time I am happy with the service, however I have had several issues, which I have brought to the attention of [registered manager]. I know my [relative] is happy at the project and is settled. Most of the staff have been very nice and sympathetic to my [relative's] needs. There are some staff who have not been sympathetic. This area of concern was addressed by the registered manager".

We saw a comment card from a relative which read, 'We are comforted that [relative] is clearly in safe hands. We are delighted with how the transition went and we think staff did a great job with [relative]. Importantly [our relative] is clearly happy and settled. Keep doing what you are doing and we look forward to the next review'.

Another family member spoken with told us they were happy with the care their relative received. They told us they felt relative was safe and well looked after.

We found risk assessments were in the care records about how to keep people safe. These covered areas such as the home environment, nutrition and personal care. This meant that staff were provided with guidance to follow if they had concerns about the safety of people who lived in the houses we visited.

As part of the inspection, we looked at how the service ensured there were sufficient numbers of staff on duty to meet people's needs. In the houses we visited, staffing levels were appropriate. We found that some staff were out with people doing different activities.

We had been made aware by the registered manager of a serious incident between two people living in one house, where the staffing levels and skill mix were insufficient to protect vulnerable people from harm. A protection plan was put in place, including increased staffing levels. This situation was investigated and successfully resolved.

We found the service had safeguarding procedures in place, which were designed to protect vulnerable people from abuse and the risk of abuse. We looked at the safeguarding process used to manage any concerns and looked at the service whistleblowing policy. This documentation provided guidance to staff on how to report concerns and what action the service would take in responding to such matters. However, following the above incident the registered manager found the staff on duty at the time of the incident had not acted appropriately and followed the correct procedures to ensure the safety of people in the home. The registered manager had put systems in place including refresher training in safeguarding procedures to help prevent any similar incident happening again.

Staff were aware of the whistleblowing procedures and had contacted the Care Quality Commission (CQC) to raise areas of concern about staffing levels in one of the houses and concerns about deployment of staff between houses. Staff felt this did not provide safe, good and consistent care to people.

We reviewed a sample of recruitment records, which demonstrated that staff had been safely and effectively recruited. Records included application forms, previous employment history, interview assessments and suitable means of identification. We found appropriate Disclosure and Barring Service (DBS) checks had been undertaken and suitable references obtained before new staff commenced employment with the service.

We looked at some people's Medication Administration Records (MARS) and saw these were completed accurately. Medication was received in blister packs and securely stored within each house. Staff who administered medication had received training and were deemed as competent to administer medicines safely. We found the service had systems in place to help ensure there was no reoccurrence of medication errors.

One parent informed us that on one occasion their relative was suffering from a headache, staff were aware of this but were unable to offer any pain relief as this was not prescribed. The family were not informed at the time of this

Requires improvement

Is the service safe?

and would have come to the home to administer paracetamol until a GP appointment could be arranged. Staff were following the correct procedures but this left this person suffering unnecessary discomfort. We were also told of a similar incident where another person with a cold and temperature was not offered pain relief despite paracetamol being prescribed and being in stock for this person. Following the inspection the service director told us that when the parent brought their relative back to the house following a home visit they said [relative] had the 'sniffles'. The service director said there was no evidence of this person having a cold and this demonstrated conflict between the family and staff.

We recommend that the service consider current guidance on managing minor ailments and take action to update their practice accordingly.

We were informed by another parent that staff missed administering medication to their relative. We were told by the relative there was no adverse effect and staff contacted the GP, however the relative was concerned how this could have happened to their relative when there were so few people living at service.

The four houses we visited were clean and well maintained. We looked at some bedrooms and saw they had been decorated taking into account people's likes and colour schemes. Communal areas were nicely decorated and suitable furnishings in place. We saw that the homes were safe and secure and where required some doors were locked to help keep people safe.

We saw that staff had completed training in fire safety and refresher training was ongoing. In the care records we looked at we saw that there was a personal emergency evacuation plan (PEEP) in place. A PEEP informs people, including the emergency services as to the help and support each person requires to assist them to a safe place.

Requires improvement

Is the service effective?

Our findings

We looked at how the service supported people with their diet. Care plans detailed guidance on the support each person required in respect of food, drink and nutrition. One parent told us, “From what I have seen, my [relative] is well fed and enjoys his meals”. Another parent made us aware they were concerned about their [relatives] excessive weight gain. The relative discussed this with the registered manager and the project manager, who did not feel there was an issue, they nevertheless agreed to organise regular weighing sessions. We were told by the family this had not been actioned. Comments from the parent suggested their wishes had not been respected. A member of staff told us that one person was cajoled by junk food in order to get them out of bed during the day.

Comments received from another parent about the food included, “Having been told regularly that [relative] eats fresh homemade meals, I was shocked when I saw that [relative] had been out for burger and chips and had curry and rice for tea. Following a health check staff were advised that [relative] needed to lose weight”.

A member of staff commented, “There is a weekly menu offering no choice to service users [people living at the home] and no pictures used to allow choice”. On the day of our inspection we did see that a healthy chicken option was being prepared for the lunchtime meal.

We recommend the service reviews the format of menus to ensure they meet people’s individual communication needs.

We looked at supervision and annual appraisal records and spoke with staff about the supervision they received. We found that staff received regular supervision, which enabled managers to assess the development needs of their staff and to address training and personal needs in a timely manner. Staff spoken with confirmed they had received supervisions. We were told by staff that the management did not always listen to people’s opinions.

We asked about staff induction and ongoing training for all staff. We were provided with the training matrix for staff in the houses we visited. One member of staff spoken with confirmed they had completed a four day induction on starting work with the service. We saw all that staff had received training in: Understanding Learning Disabilities and Autism, Breakaway Techniques, Physical Intervention, medication, Manual and People Handling Awareness, Emergency First Aid and Food Safety in the workplace.

We looked around four of the houses and saw that these were suitably equipped with aids and adaptations to meet the needs of the people living there.

We saw there were relevant risks assessments in place for example, trips out of the home, mobility and falls. We saw that people had access to GPs and hospital appointments and could be escorted by staff if required or by a family member.

We checked whether the service was working within the principles of the Mental Capacity Act (2005) (MCA). The Mental Capacity Act (2005) provides a legal framework for making particular decisions on behalf of people who may lack capacity to do so for themselves. The Act requires that as far as possible people make their own decisions 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 it’s in their best interest and legally authorised under the MCA. Staff spoken with confirmed they had undertaken training on MCA and DoLS which we verified by looking at the training matrix and staff files. Staff spoken with during the inspection were able to demonstrate they had a good understanding of MCA and DoLS.

Requires improvement

Is the service caring?

Our findings

One family member told us, “The staff are all great and friendly and we get great feedback when we visit. We are very satisfied with the care [relative] receives. The staff seem generally interested in [relative’s] development and often ask us how to try and move things forward”.

Another parent told us, “I was told that in adult services that they are not allowed to make people do things, if they say no a couple of times, that it is no. This is taken literally as it’s the way staff were shown at the start; There is a major difference between forcing them and coaxing them to do something in their best interest. I’ve had issues with staff understanding that I’m his mum and I haven’t given up my rights and therefore my thoughts and opinions count and more importantly I know [relative] better than anyone. To be told what’s best for your son and when you make a suggestion, told your wrong is humiliating and this happened regularly”. Although regular reviews involving relatives were held, parents’ wishes were not always respected.

On the day of the inspection staff spoken with had a good understanding of the care needs of the people they were supporting. They could explain what triggered certain behaviours and how this was addressed. Care staff introduced the inspector to people and to maintain their privacy asked if it was acceptable for us to look around their home.

We saw that people were well dressed and in appropriate clothing. One parent commented that when they saw their relative they were always clean and tidy and wearing his own clothes. However, another parent has told us that they had to raise concerns around their relative’s personal hygiene. When this was raised with the staff they did not deem this an issue.

It was also brought our attention that staff had bought one person a pair of training shoes. The family thought these were too narrow and conveyed this to the staff. The family told us it was evident that the shoes had been worn and two blisters were noted of their [relative’s] foot. The staff response was, “He didn’t complain when he wore them”. The response from the staff was not acceptable and neither took into account the concerns of the family or the discomfort caused to a person in their care.

Another parent told us they were extremely distressed when their [relative] was on a home visit and on getting them ready for bed found they had been dressed all day in small underwear when large or extra-large was required. This resulted in the groin area being red, sore and badly marked. They said [relative] had suffered all day as they did not know how to communicate pain. This was brought to the attention of the service and addressed at the time.

One family felt there was nothing to be gained by having any further meetings with the management until their relative’s next review as issues they raised often re-occurred. This meant that the care and welfare for some people was not being delivered as some parents expected. These concerns raised by parents were relating to one house in particular.

We were told by one parent, “This was the hardest decision any parent has to make, to have my [relative] live away from home as I could no longer look after them. The people living in any of the homes were extremely vulnerable and rely heavily on the staff for good care”. We were told that staff at one of the houses had received training in end of life care. The team wanted to ensure they were adequately equipped to care for one person who was very poorly and was approaching the end of their life. Staff were supported by the district nurses and the MacMillan team. A comment received from a healthcare professional involved with this person stated, ‘As a healthcare professional I would like to say that the support, care and compassion the team showed was heart- warming and I hope as a collective you can all take some comfort in the knowledge that you all treated [person using the service] with dignity allowing him to remain in his own home’.

Requires improvement

Is the service responsive?

Our findings

The care records we looked at contained detailed information including a social history, information from previous care settings where they had lived at. There was input from families and other healthcare professional involved with their care. There was a 'pen profile' to guide staff, including any agency staff on what was important to the individual and how the care and support should be delivered.

There was a section called my health action plan, details of current medication, information from the Speech and Language Team (SALT) and a hospital passport which was a document that would be taken with the person in the event of a hospital admission. This provided hospital staff with important information about the person. Specific training, for example caring for people with epilepsy was provided to staff as required.

We were told by staff that people had a structured day and were provided with a wide range of activities. People who used the service, and with consultation with families were to be supported with daily activities. Some people had their own mobility car for trips and outings and we were told that staff took this person out on activities.

One parent told us, "My [relative] goes out most days, if not every day. The activities that [my relative] can access are limited but the staff keeping seeking out new adventures that they think [my relative] would enjoy".

Two parents told us that they had concerns about indoor activities at the home and how a lot of these were centred around watching the television, computers and IPads. We were told by the parents that some time on IPads was deemed acceptable but for their relative's wellbeing they need other things to occupy and to stimulate them.

One parent told us they felt their relative was being de-skilled and they had provided games and equipment for staff to use in the home. The member of staff told a parent, "They didn't play games, I just do activities". Another parent said that on three occasions a member of staff's idea of a good activity was a trip to a local supermarket for lunch and one comment recorded stated, "Wandered round Sainsbury's – too wet for a walk". Again this family had provided activity equipment for both indoor and outdoor, but from the activity records provided to the family it was clear that these items were very rarely used. The parent said that when they requested staff to confirm what activities they had planned they were sometimes unable to confirm what had been organised for the next day or the forthcoming week. This had been discussed with the project manager and with the registered manager however the situation remained the same.

We saw that the service had systems in place for receiving and dealing with complaints. People had raised issues with the project managers and the registered manager but told us that a satisfactory resolution had not been actioned. We were provided with a copy of the Contract Report from June 2015 to August 2015, which stated no complaints had been reported during this period. The registered manager may not be aware of some of the concerns raised.

We recommend the service ensures that all complaints are logged, addressed and audited.

One parent from another house we visited told us that staff working with their relative listened to them and acted upon any issues raised. This meant that some staff in the houses we visited responded differently to issues raised and actions taken.

Requires improvement

Is the service well-led?

Our findings

There was a registered manager at the service. A registered manager is a person who had 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 had policies and procedures in place, which covered all aspects of the service delivery. The policies and procedures included safeguarding, medication, whistleblowing and recruitment. Following a recent incident we were made aware that some staff did not follow the correct procedures with regard to a safeguarding incident. This had been addressed and further training and support provided. We saw that in the houses we visited that a safeguarding flow chart was in place to prompt staff on what action needed to be taken and who to contact. Staffing levels and the skill mix of the staff had reviewed to help ensure people were kept safe.

We looked at how the service learnt from any incidents and safeguarding matters. The service was able to demonstrate to us where lessons had been learnt, what immediate action had been taken and how learning had been shared with staff. Examples included safeguarding and staffing structure.

We found that regular reviews of care plans and risk assessments were undertaken. Regular supervision and staff meetings were also undertaken by the project managers. These meetings provided staff with the opportunity to discuss any concerns they may have and any further training and development they may wish to undertake.

We found the service undertook a range of checks to monitor the quality of the service delivery. This also included spot checks and observations of staff practice.

The registered manager organised a regular family forum meeting. The inspector attended the December 2015 meeting which was held at Creative Supports office in Bolton. These meetings provided family members with the opportunity to meet with staff and discuss different topics.

The registered manager attended regular multi-disciplinary team meetings with other health and social care professionals. These meetings ensured good working partnerships with all professionals involved with the care of people who used the service.

We received mixed comments about the running of the service from staff spoken with. We were told by senior staff that the service was well managed and well run. Some staff told us they sometimes felt they were not being listened to by the project managers or the registered manager and that some of their concerns were brushed aside. Two relatives spoken with told us that despite their concerns being raised with the registered manager no action had been taken.

Providers are required by law to notify CQC of certain events in the service such as serious injuries, deaths and safeguarding concerns. Records we looked at confirmed that CQC had received all the required notifications in a timely way from the service.

This section is primarily information for the provider

Action we have told the provider to take

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