Care Quality Commission

# Care Management Group Limited

# The Paddocks

## 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 inspection took place on 14 and 16 January 2015 and was unannounced. This is a summary of what we found.

We last inspected this service on 15 October 2013 and we found it to be compliant at that time.

The Paddocks is an eight bed service providing support and accommodation to people with a learning disability, autism and behaviours that challenge. It is a large, purpose built, single storey house a short walk from the town centre where there is a wide range of local community facilities. The house does not have any special adaptations but is accessible throughout for people with mobility difficulties or who use a wheelchair.

The service did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

# Summary of findings

People were not always safe at the service. Staff did not have a good understanding of safeguarding and how to recognise and prevent abuse from happening. Risks to people were not sufficiently managed, however relatives and care managers told us they were satisfied about people's safety at the service.

The staff team worked with other professionals to ensure that people were supported to receive the healthcare that they needed.

Some staff had not completed Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Deprivation of Liberty Safeguards is where a person can be lawfully deprived of their liberties where it is deemed to be in their best interests or for their own safety. However, we saw that when this was necessary to keep people safe, the proper process had been followed to obtain agreement from the supervisory body.

Information was not available in a way that helped people to understand it and staff did not have the skills to communicate effectively with people. This meant that people's involvement in how they were cared for and supported was limited as they could not always communicate their wishes. However, we found that relatives visited regularly and were involved in discussions and decisions about the service people received.

People chose what they wanted to eat and drink. Staff supported them to eat and drink enough to meet their nutritional needs.

People were not receiving a specialist service as stated in the provider's information. Staff had not received the training they needed to provide a safe and appropriate service. They were not sufficiently skilled to meet people's complex needs.

The provider monitored the quality of the service and when major concerns were reported the provider responded and took action to address the problems. Systems were in place to respond to any concerns or issues that affected people who used the service.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of this report.

# Summary of findings

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

We always ask the following five questions of services.

**Is the service safe?**

Not all aspects of the service provided were safe. Staff did not have sufficient knowledge to identify the possibility of abuse and prevent it from happening.

People were not sufficiently protected from risks.

People received their medicines safely and appropriately.

**Requires Improvement**

**Is the service effective?**

Not all aspects of the service provided were effective. The staff team had not received all of the training they needed to ensure that they supported people safely and competently.

Systems were in place to ensure that people's human rights were protected and that they were not unlawfully deprived of their liberty.

People were supported to receive the healthcare that they needed.

People were provided with a choice of suitable, nutritious food and drink.

**Requires Improvement**

**Is the service caring?**

Not all aspects of the service provided were caring. People received one- to-one or two- to-one staff support but we saw that some staff did not positively engage with the person they were supporting.

People's privacy and dignity was maintained in as far as was practical given that each person received one to one staff supervision.

Relatives felt that the staff team were caring.

**Requires Improvement**

**Is the service responsive?**

Not all aspects of the service provided were responsive. People were not involved in the planning of their care. Information was not available in a format that made it easier for them to follow.

People's care plans were not sufficiently detailed to enable staff to provide a personalised service that met their complex needs.

Activities were limited and relatives felt that people did not "do enough."

The service had a complaints procedure and action had been taken to address concerns and complaints. Relatives felt that the provider had been responsive to their complaints.

**Requires Improvement**

**Is the service well-led?**

Not all aspects of the service provided were well-led. There had not been a registered manager in post since March 2014 and at the time of the inspection there was not a manager in post.

**Requires Improvement**

# Summary of findings

There had been major concerns about the service but when this had been escalated to the provider, they had taken action to address the issues raised. Relatives were happy with the action.

The provider had systems in place to monitor the quality of the service provided but these did not always identify issues in a timely manner.

# The Paddocks

**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 14 and 16 January 2015 and was unannounced.

The inspection team consisted of a lead inspector and specialist learning disability professional.

Before our inspection, we reviewed the information we held about the service. We contacted the commissioners of the service and healthcare professionals to obtain their views about the care provided.

During our inspection we spent time observing care and support provided to people in the communal areas of the service. We spoke with five people who used the service, six staff, two care managers and four relatives. We looked at four people's care records and other records relating to the management of the home. This included four sets of recruitment records, duty rosters, accident and incident records, complaints, health & safety and maintenance records, quality monitoring records and medicines records.

Requires Improvement

# Is the service safe?

## Our findings

Care provided was not always safe. Staff told us and records confirmed that most had completed safeguarding adults e-learning training. However, staff spoken with did not demonstrate a good understanding of safeguarding people. For example, one member of staff knew only the basic principles of safeguarding and another could not remember their safeguarding training. Therefore people were not adequately protected from the risk of abuse, because staff did not have sufficient knowledge to identify the possibility of abuse and prevent it from happening. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service were not sufficiently protected from risks. Their care plans covered areas where a potential risk might occur. A number of staff had left the service and therefore there were new staff in post. We found that there was a system in place whereby staff signed to say that they had read people's plans and risk assessments. However staff signature forms were poorly filled in with in some instances only two staff having signed that they had read it. We saw that one person had a risk assessment that related to eating but the staff supporting that person did not follow the guidance to minimise risk and this placed the person at risk of choking. People who used the service were not protected from the risk of receiving care that was unsafe. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

With the exception of one relative the relatives and care managers we spoke with were satisfied that people were safe at the service. They acknowledged that there had been some issues that affected people's safety but felt that the necessary action had been taken to address the problems. One person told us, "[my relative] is definitely safe there."

The provider had a satisfactory recruitment and selection process in place. This included prospective staff completing an application form and attending an interview. We looked at the files of four recently recruited members of staff. We found that the necessary checks had been carried out before they began to work with people. This included proof of identity, two references and evidence of checks to find out if the person had any criminal convictions or were on any list that barred them from working with vulnerable adults. When appropriate, there was confirmation that the person was legally entitled to work in the United Kingdom. People were protected by the recruitment process which ensured that staff were suitable to work with vulnerable adults.

The provider had appropriate systems in place in the event of an emergency and there was an emergency contingency plan. Staff told us that there was an on call system and also that the provider's other services on the same site could be called upon for assistance in an emergency. Systems were in place to keep people as safe as possible in the event of an emergency arising.

Staffing levels reflected the needs of the people who used the service. During the day five people received one-to-one staff support and the sixth two-to-one. At night three staff were on duty. From our observations and discussions with staff, care professionals and relatives we found that staffing levels were sufficient to meet people's needs.

Medicines were securely and safely stored in appropriate individual metal cabinets in a designated room. There were also appropriate storage facilities for controlled drugs. Keys for medicines were kept securely by the person designated to administer medicines to ensure that unauthorised people did not have access to medicines.

Medicines were ordered, stored and administered by staff who had received medicines training and had been assessed as competent to do this. Competency was reassessed at least once a year and more often if necessary. For example, if a medicines error or issue arose staff did not administer medicines until they had been reassessed as competent. We saw evidence of this in staff files. Competency was assessed and monitored by the deputy manager who had completed specific training to enable them to do this. We found that medicines audits were carried out each month and that medicines not stored in sealed packs from the pharmacist were checked and counted twice daily to ensure that people had been correctly given their medicines. This meant that there were systems in place to check that people received their prescribed medicines safely and appropriately.

We looked at the medicines administration records (MAR) for three people and saw that these included clear

Requires Improvement

# Is the service safe?

information on 'how to support me with medicines'. We saw that the MARS had been appropriately completed and were up to date. We checked the stock levels of medicines for three people against the medicines records and found that these tallied. We also counted the controlled drugs and these tallied with the controlled drugs register. Therefore people had received their prescribed medicines.

None of the people who used the service required any specialised equipment. Records showed that other equipment such as fire safety equipment was available, was serviced and checked in line with the manufacturer's guidance to ensure that they were safe to use. Gas, electric and water services were also maintained and checked to ensure that they were functioning appropriately and safe to use. People were therefore cared for in a safe environment.

Requires Improvement

# Is the service effective?

## Our findings

The service was not effective. The provider's information leaflet stated, "The Paddocks is a specialist residential service for adults with learning disabilities and additional complex needs including autism and challenging behaviour." However a specialist service was not provided. Feedback from social care professionals was that staff did not have specialist knowledge and that there had been a reliance on external professionals to provide guidance and support.

Feedback from relatives was that the service had not been effective and people had not been receiving the care and support that they needed. They told us that people had not been supported in consistent manner and that this had affected the way in which they behaved. They also felt that staff needed more specific training to enable them to effectively support people's needs. This included communication, autism and managing behaviour that challenged. However, relatives added that there had been some recent changes 'for the better'. Three of the four families we spoke with told us that overall their relatives were more settled and that their behaviours that were challenging had improved. A care manager told us that they would have no qualms about placing a person in the service.

We found that staff did not have the experience and had not received training to enable them to effectively support people's complex needs and behaviours. For example, one member of staff told us that they had not received any training specific to autism. Also we observed a person using Makaton (a method of sign language communication for people with learning disabilities) but the member of staff supporting that person did not sign back and had not received Makaton training.

Some staff told us that they had not received Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards (DoLS) training. MCA is legislation to protect people who are unable to make decisions for themselves. DoLS is where a person can be deprived of their liberty where it is deemed to be in their best interests or for their own safety.

The shortfalls in training were confirmed in a service improvement plan that indicated that staff were not up to date with their e-learning or with service specific training.

This meant that people were not cared for by staff who had the necessary skills and knowledge to meet their assessed needs. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to people's complex needs a number of restrictions were in place. For example, each person had one-to-one staff support at all times during the day. If the person was in their room staff waited outside. We found that as a result of this, applications for DoLS had been made to supervisory bodies and the provider was awaiting their responses. At the time of the visit one person had DoLS in place. This person's relative told us that they were aware of the DoLS and had been involved in discussions about this and agreed that it was in the person's best interest. Systems were in place to ensure that people's human rights were protected and that they were not unlawfully deprived of their liberty.

People were provided with a choice of suitable, nutritious food and drink. They chose what they wanted to eat and were encouraged to have a healthy diet. None of the people needed a specialised diet due to their religion or culture but staff told us that this could be accommodated if the need arose. If people wanted a drink they indicated this to staff and were then taken to the kitchen to get one. Relatives were involved in supporting people to have a healthy diet and for one person their relative had produced a menu which staff followed. Another relative said that they had raised concerns about their relative's diet and weight. This had been addressed by the service and they were now satisfied that their nutritional needs were being met. People were supported to be able to eat and drink sufficient amounts to meet their needs.

There had been some gaps in staff supervision (one to one meetings with their line manager to discuss work practice and any issues affecting people who used the service). However, this had been identified by the provider and was being addressed. Monthly staff meetings were arranged and this gave staff the opportunity to discuss the service provided and to share information. Therefore systems were in place to support staff to carry out their duties.

We found that people were supported to maintain good health and had access to healthcare services. People saw

Requires Improvement

# Is the service effective?

professionals such as GPs, dentists, social workers and psychiatrists as and when needed. People's healthcare needs were monitored and addressed to ensure that they remained as healthy as possible.

The service was provided in a purpose built bungalow divided into three units. It was situated in a rural setting a short walk from the town centre where there was a range of local community facilities and transport links. There were not any environmental adaptations as people did not require this. Some flooring needed replacing and this had already been agreed by the provider. Although there was some personalisation in people's rooms the overall environment was very bare and did not reflect the likes and interests of the people who used the service. For example, all the walls in the communal areas and people's own bedrooms were the same colour and in many areas needed re decorating. Some of the furniture was worn. There were some photographs on walls but these were quite old and torn and looked untidy. In the living room there was a reward chart on the wall which did not appear to be in use and again was torn. We recommend the provider review the design and decoration of the service premises in line with guidance on environment and surroundings from the National Autistic Society.

Requires Improvement

# Is the service caring?

## Our findings

The service was not always caring. We saw that some staff did not positively engage with the person they were supporting. They just 'followed' people when they were walking around and then remained in the room with people to maintain the one-to-one supervision. We saw that staff treated people with respect and that they spoke to them politely, however the lack of systems to facilitate good communication meant that people were not always provided with explanations or information or given the means to respond appropriately. For example, one person's picture exchange communication system (PECs) was not being used. This meant that the person was not always enabled to express what they wanted or how they were feeling.

We saw that people's privacy and dignity was maintained in as far as was practical given the levels of supervision that they needed.

We saw that people were encouraged to do things for themselves in some areas and information on this was in individual plans. For example, staff asked a person what they would like to drink and then got the items and encouraged the person to make their own drink. We saw that another member of staff encouraged a person to eat with knife and fork. However restrictions placed on people due to their behaviours meant that they were reliant on staff to do things for them. For example, the kitchen was kept locked and one person was not allowed to go into the kitchen. Therefore staff made their meals, drinks and snacks. Reducing the restrictions placed on people, with regard to the kitchen, formed part of the service improvement plan. Once completed people would have access to their own cupboard in the kitchen and to kitchen facilities. They would then be able to develop and use their skills and independence in that area.

Overall feedback from relatives was that staff were caring. This was mainly in relation to staff that had been working at the service for a while and who knew people well. For example, one person told us that their relative had quite good relationships with some of the staff. Another said, "All the staff are caring. [Our relative] is happy and relaxed there."

Requires Improvement

# Is the service responsive?

## Our findings

The service was not always responsive. Relatives told us that they felt that the service had not been appropriately responsive to people's needs but that this had now changed. One relative told us, "Things were back on track."

Care files did not indicate involvement by the person in the planning of their own care. They were not in a format that would have made it easy for people to understand. We found that systems in place to enable people to communicate their wishes and feelings were not robust. The need for visual resources for communication was part of the service improvement plan Care and support was not provided in line with people's preferences and interests. However we saw that relatives were involved and that they attended reviews. One relative told us that staff were interested in what they had to say. A care manager said that the service had responded to changes requested by one person's family.

People's files contained information about how to support them and how to respond to their behaviours. This included using 'Positive Behavioural Support' (PBS). This is a method of working with and responding to behaviours that challenged. However we found that in one person's file the PBS information was general and not specific to the individual. However staff felt that the person's care plans were sufficient as when followed they did work even though they were concerned that they appeared to be rewarding inappropriate behaviour. They also felt that the care plan could now be updated as staff knew more about how best to respond when the person was anxious. People's care plans were not personalised and comprehensive. They did not describe the individual support people required to meet their specific needs and to enable staff to respond appropriately to these.

Relatives told us that they felt people were 'not doing enough' and that activities needed to improve. Each person had either one-to-one or, in one case, two-to-one staff support that should have enabled them to participate in activities of their choice. There was an onsite activity centre but that was not open at the time of our visits. On the days of the visits, people were not always engaged in meaningful activity although some people went out with staff. We saw that one task on the improvement plan was to identify and action activities in house and in the community. This included sourcing college courses and using the activity centre when it reopened. People were not adequately supported to take part in activities that they chose and which maintained their wellbeing.

There had been a number of staff changes and in December 2014 there were 9.5 staff vacancies. Some new staff had been employed and recruitment was on going. This had meant that there had been a reliance on agency and bank staff. This had changed as new staff began to work at the service but meant that staff were still getting to know people and vice versa. We found that some staff were therefore not sufficiently aware of people's care plans, risk assessments or how to respond to them. However, overall feedback from relatives and care managers was that although people had behaviour that challenged the frequency and severity of this had lessened.

The issues above all evidence a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not receive a person centred service that responded to and met their needs.

Staff supported people to maintain relationships with their friends and family. The four relatives we spoke with all visited regularly. One family told us that staff had worked very hard and flexibly to support their relative to visit the family home. They said that they could not speak highly enough of the staff that had been involved in this.

There was a complaints procedure in place. Relatives told us that their complaints had not always been adequately addressed but they now felt that the provider had taken this on board and was responding to them. Systems were now in place to take people's complaints and experiences into account and to use this information to develop and improve the service provided.

Requires Improvement

# Is the service well-led?

## Our findings

The service was not always well-led. There had not been a registered manager in post since March 2014 and at the time of the inspection there was not a manager in post.

Relatives told us that there had been some major concerns about the service but when they had escalated these to the provider they had been listened to and action was taken. They felt that in terms of the provider, the service was well-led. Relatives told us that when they raised the concerns they had been allocated a 'family liaison officer' to support them. They said that the provider had "listened, engaged and supported". We saw that the provider had taken some immediate action to address the concerns and put an improvement plan in place to address the shortfalls that had been identified in the service.

The provider had a number of different ways in which they monitored the quality of service provided. Quality audits were carried out four times a year by a regional director. A report of their findings was then sent to the manager for any issues to be addressed. The provider sought feedback from stakeholders (relatives and other professionals) by yearly quality assurance surveys. There had not been a recent survey but the next one was planned for March 2015. Therefore, people were provided with a service that was monitored by the provider. However, improvements were needed to ensure that any issues were identified at an earlier stage. This would mean that more timely action could be taken to ensure that people were receiving a service that met their needs.

Providers of health and social care have to inform us of important events which take place in their service. Our records showed that the provider had told us about such events and had taken appropriate action to ensure that people were safe.

The deputy manager and an area director were overseeing the service whilst a new manager was being recruited. Staff told us that they received support and guidance from the deputy manager and from shift leaders. Shift leaders were responsible for the daily running of the shift and there was always a team leader on duty during the day time. At night the on call system was used if staff needed any support or guidance. Relatives told us that they had already started to see changes for the better, therefore suitable interim management arrangements were in place whilst a manager was being recruited.

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.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>People who used the service were not supported by staff who had received appropriate training to enable them to deliver care to an appropriate standard. Regulation 18 (2). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>People were not adequately protected from the risk of abuse, because staff did not have sufficient knowledge to identify the possibility of abuse and prevent it from happening. Regulation 13 |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>People were not protected against the risks of receiving care and treatment that was unsafe or inappropriate. Regulation 12 (2) (a)-(c) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br><br>People did not receive a person centred service that responded to and met their needs. Regulation 9 (1) &(3) (b) & (h). |