Creative Support Limited

Creative Support - Elkin Court

Inspection report

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Ratings

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

Overall summary

We undertook an unannounced inspection of Creative Supports' care provision at Elkin Court on the 24 March 2015 and the 27 March 2015, as the result of concerns raised by people contacting the Care Quality Commission. The inspection was unannounced which meant the provider did not know we were coming.

Staff from Creative Support provide personal care services to people in their own flats who are tenants at Elkin Court. Elkin Court is an extra care scheme and people living there are tenants of Housing 21. There are 40 flats within the service and Creative support are commissioned by Trafford Borough Council to provide personal care to 20 people living there.

This was first time this service has been inspected by the Care Quality Commission.

The registered manager for this service was not based solely at Elkin Court as they were also registered manager for another service in Salford. The registered manager was present during the inspection along with the service director. A registered manager is a person who has

Summary of findings

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.

We spoke with seven people who were supported by Creative Support. All told us they did not feel safe and were not fully satisfied with the service being provided by Creative Support. People made positive comments about the staff and the care they received if they had regular care workers providing all or some of their care but they said they didn't feel safe being supported by "strangers" and/or inexperienced staff who needed more training. We found the service had not made sure there were sufficient staff with the right knowledge and experience to support people to an appropriate standard.

The service did not have appropriate arrangements in place to manage medicines safely to ensure people were protected from the risks associated with medicines.

The service had not completed regular care plan reviews with people using the service. Individual risk assessments were completed for people so that identifiable risks were managed but these were not being regularly reviewed to ensure they reflecting people's changing needs.

Staff were able to describe how they respected people's privacy and treated people with dignity and respect. They told us however that they were concerned people could not always be supported in the correct way because they did not have the time. They said more staff were needed. Some people felt they were not treated with consideration and respect by agency staff.

People we spoke with who used the service were concerned that agency staff had not been properly trained to enable them to deliver care to an appropriate standard. We found that agency staff competency had not been checked prior to them supporting people on their own. Staff training records were out of date and arrangements had not been made to ensure all staff received regular supervisions which meant performance was not formally monitored and areas for improvement may not have been identified.

The provider had a complaints process in place. This was out of date and had incorrect information contained within it. The provider did not have an effective system in place for identifying, receiving, handling and responding appropriately to complaints and comments made by people or persons acting on their behalf.

The provider had not ensured there were effective systems in place to monitor and improve the quality of the service provided. This meant they were not meeting the requirements to protect people from the risk of unsafe care by effectively assessing and monitoring the service being provided.

We found there were breaches in the regulatory requirements of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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?

Inadequate

Some areas of the service was not safe.

The service had not made sure there were sufficient staff with the right knowledge and experience to support people.

People told us they did not feel safe being supported by strangers and/or inexperienced staff who need more training.

The service did not have appropriate arrangements in place to manage medicines to ensure people were protected from the risks associated with medicines administration.

Is the service effective?

Requires Improvement

The service was not effective for all people.

Staff had not been supported to deliver care and treatment safely and to an appropriate standard. Staff refresher training was overdue so staff had not been supported to maintain and update their skills and knowledge.

People were not receiving support which was outlined in their care plan.

The care plans did not always reflect people's health care needs.

Is the service caring?

Requires Improvement

Some areas of the service was not caring.

During the inspection we received negative feedback from people using the service. A few people told us they were not treated with consideration or respect.

Regular staff working at the service knew people well and were able to describe how they maintained people's privacy and dignity.

Is the service responsive?

Requires Improvement

Some areas of the service was not responsive.

We found the service had failed to ensure the planning and delivery of care met the needs of individual people using the service. Some people did not experience continuity of care.

We found the service had not responded to some people's and/or their representative's concerns effectively and the action taken had not been sufficient to address their concerns.

Is the service well-led?

Inadequate

The service was not well-led.

Summary of findings

There were no checks completed by the registered manager and provider to assess and improve the quality of the service. This meant people were not protected against the risk of inappropriate or unsafe care.

Information requested was not always readily available due to ineffective filing systems and storage.

Creative Support - Elkin Court

Detailed findings

Background to this inspection

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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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 24 March 2015 and 27 March 2015. This was first time the service had been inspected by the Care Quality Commission. This was an unannounced inspection which meant that staff and the provider did not know we would be visiting.

The inspection team consisted of two adult social care inspectors. We spoke with nine people living at Elkin Court, seven who received a service from Creative Support. We spoke with five staff including the registered manager, service director and senior staff as well as agency staff. We spoke with two relatives and two visitors of people living at Elkin Court.

The Creative Support service at Elkin Court provides personal care services to people in their own homes. At the time of our inspection 20 people were receiving a personal care service from Creative Support.

Before our inspection we reviewed the information we held about the service and the provider. For example, notifications of deaths and incidents. We also gathered information from Trafford local authority.

We reviewed a range of records including care records, medication administration records, and records relating to the management of the service.mmary here>

Inadequate

Is the service safe?

Our findings

People we spoke with told us they did not feel safe because they did not like being supported by care workers who were "strangers" and by inexperienced staff who needed more training. For example, one person told us there was " a lot of agency staff coming in", "Agency staff change all the time". And "it's only a matter of time before something bad happens". People told us they felt unsafe whilst being supported by inexperienced staff members. Another person told us they dreaded the days their regular worker was off as they didn't know who was going to be supporting them.

Most of the people spoken with told us they didn't know who the agency staff were as they did not wear a uniform. On the first day of inspection we saw an agency worker had started their first shift that morning. They were not in uniform and people we spoke with did not know they were staff. Elkin Court had facilities such as a shop, hairdressers and café area which was accessible by members of the public. People told us if staff don't wear uniforms they may place themselves at risk by mistakenly allowing someone into their home thinking they were a staff member from the service. This was a concern to us as it would be easy for a stranger to gain access into people's homes. The senior worker told us this did not usually happen and agency workers usually wore uniforms. They told us they would address this issue immediately and ensure they had a range of different sized uniforms available to staff.

One person who received support from Creative Support raised concerns with us regarding the competency of staff to administer medication. They told us they needed support to take their medicine. One of the medicines they received was a controlled drug. Controlled drugs are a particular type of drug which must be managed carefully. This means particular care must be given when administering these drugs due to the risk of harm if they are taken incorrectly. The person we spoke with told us the agency worker who was on at night had given them too much medicine. They said this was because they had needed to rush to another flat as someone had fallen. They also told us the staff member had left the medicine out. Controlled drugs must be kept locked away at all times. We checked the controlled drugs records and found a number of errors. We saw this person, on more than one occasion had received an incorrect dosage of the controlled drug. The records were not kept correctly and the dates did not correspond to the drugs administered. This meant people were at risk of unsafe care and treatment. We spoke with the registered manager who agreed this practice was unacceptable.

We found this to be a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered person did not protect service users against the risks associated with the unsafe use and management of medicines. We spoke with the registered manager and instructed an immediate safeguarding alert be sent to Trafford Local Authority.

Of the seven people spoken with, nobody was fully satisfied with the service being provided by Creative Support. People made very positive comments about staff if they had regular care workers providing all or some of their care. However, people told us they wanted regular care workers who came at regular times who had been trained properly.

Staff comments regarding the staffing issues at the service included: "we have recently had two full time staff leave which has impacted massively on our ability to provide good care. People are not getting the care they are paying for, we work hard trying to please everybody but we cannot do it with the amount of staff we have at the moment."

We observed during the first day of inspection there were three staff on duty. One was a senior member of staff, one was a regular member of staff and one was an agency staff. The senior staff was busy with the inspectors and the agency staff was observed standing around in the dining area. This meant there was only one staff member delivering the care to people requiring morning support.

Regular staff had received training in safeguarding vulnerable adults as part of their induction training. Regular staff we spoke with understood their responsibilities to ensure people were kept safe and knew how to raise any safeguarding issues in relation to abuse.

We looked at people's care records. People had individual risk assessments in place so that staff could identify and manage any risks appropriately. The purpose of a risk assessment is to identify any potential risks and then put measures in place to reduce and manage the risks to the person. However, we found that people's risk assessments were not being regularly reviewed and were out of date. This meant people were at risk of receiving unsafe care and

Inadequate

Is the service safe?

support which may not be appropriate for their needs. Staff we spoke with said this was due to the number of agency staff being used which meant there was not a cohesive team to update the risk assessments.

There was a process in place to ensure safe recruitment checks were carried out before a person started to work at the home. Staff attended an interview and satisfactory references and disclosure and barring checks were obtained. However, due to the high numbers of agency staff being used it was difficult to ensure the correct level of skilled and experienced staff was available for people who used the service at all times.

The service director told us they found it difficult to recruit staff due to the location of the service. We did not consider sufficient steps had been taken by the service to ensure people received safe care. We found that people's health, safety and welfare had not been safeguarded because there was not sufficient numbers of suitably skilled and experienced staff. These findings evidenced a breach of Regulation 22 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.

Requires Improvement

Is the service effective?

Our findings

People who used the service did not raise any concerns about staff who were experienced regular care staff. People's comments included: "my regular workers are all very good, they know us well. They do their best, not enough staff though". However, people expressed concerns about the training and competency of agency staff. Peoples comments included: "they need training in basic things, some of them [agency staff] don't know what to do, they come and ask us what they are supposed to be doing", "and I think they get told what to do but they seem a bit worried when they are left alone at night. They don't know our door codes so wake us up to come in or leave the door unlocked which worries me."

A few people described how some staff would ask them what tasks they wanted completing and said staff did not read their care plan. (Care plans were kept in each person's flat.) Their comments included: "I am alright I can tell them what to do, I worry for the other people who are not able to tell them. How do they go on?".

Relatives also expressed concerns about the training and competency of agency staff. Their comments included: "I would rather not receive care from them [agency workers] I would rather provide it to [spouse] myself".

We asked to see the training plan for staff for the next 12 months. The information was not made available to us as it could not be located. The registered manager told us it was out of date. We saw the provider, Creative Support, had a full and comprehensive training calendar which was not being utilised effectively for the staff at Elkin Court.

We saw some staff records which had outlined training for some of the staff and staff we spoke with confirmed they had attended the training and had found it useful. We spoke with the registered manager who told us the senior staff was currently reviewing the training plan and this would be available in the next few weeks. We saw supervisions had taken place and staff told us they had found the supervisions useful.

We received mixed views from care staff about the support they received from senior staff and management. Comments included: "The registered manager is never here so we get no support but it is getting better since we now have a senior. She is approachable and understands". Other comments were: "best company I have ever worked for, it was great before the staff left it is a lovely place."

We had received information of concern that people were not receiving the correct level of support at mealtimes. We did not see evidence of this during our visit but one person told us, "Sometimes I get calls at the wrong times which means I may have just had lunch so don't want my tea if they come early. It is frustrating, I do get enough to eat and drink but I am never sure what time, sometimes breakfast is late which means I don't want my lunch."

We found there were a number of care files and assessments within care files for each person. Most were out of date. Along with the notes kept by staff from Creative Support we saw there were notes kept by district nurses. We reviewed the information in each set of notes and found it was not consistent or clear. For example in one care plan from Creative Support there was no mention of the leg ulcer referred to in the District Nurse's notes on their 'running daily' records. We also saw evidence to suggest all the information held about a person was not condensed into one comprehensive care plan. This made it difficult for new staff to know about each person which meant people were at risk of receiving inappropriate care and treatment.

We found staff consistently writing "no concerns" when the continence record chart detailed issues regarding continence. Daily records did not truly record or evidence any escalation of concerns by staff regarding pressure sores when cross referenced with the District Nurse's notes.

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. This was because the service did not monitor and record people's health and care needs and could not be sure care and treatment was being offered as directed in their care plan.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and to report on what we find. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests.

Requires Improvement

Is the service effective?

We found the registered manager and the staff we spoke with understood the principles of the MCA and had had appropriate training. What they told us meant they understood what processes they needed to follow when applying the principles of the Act. This meant people who did not have the capacity to make decisions for themselves would be supported to access the correct level of support to meet their needs.

Requires Improvement

Is the service caring?

Our findings

We received mixed views regarding the staff working at Elkin Court. Some people made positive comments about the staff in particular their regular workers. These included, "The regular staff are great, they look after us, they try hard. "People's mixed comments included: "We don't know who is in charge, we are not told about anything. We understand about confidentiality but we should be told what is going on". And "I am not treated with dignity and respect but accept now that is the way it is, some carers treat you better than others, the agency staff are a real problem, some have a bad attitude."

During our inspection we observed regular staff were kept busy all day. During the lunchtime period one member of staff was doing the medicine round. We observed them knocking on people's doors before entering and consideration given to visiting relatives and the person's wish for privacy before administering their medicine to them. We saw the other regular member of staff supporting people in the dining area of the café. We saw there was good interaction between the people who used the service and this staff member. We observed the agency worker was shadowing this staff member but they did not communicate with anyone in the dining area.

Some people we spoke with told us they were not involved in their assessment of needs. We looked at these assessments and found they were not person centred and did not direct staff on how to support someone in the way they wanted. We saw some assessments were done in 2012 and there was no evidence to suggest they had been updated. The registered manager said they thought they may have been but staff had not changed the date. Staff we spoke with said they didn't have any time to update them as often as they would like and agency workers did not really contribute which led to gaps in the records. We saw evidence that the assessments were not in line with current assessments from the district nurses. Regular staff we spoke with were able to tell us about people's needs, agency staff were not which meant at times when agency staff were used people were at risk receiving unsafe care and treatment.

We saw that due to the low staffing levels staff did not always respond to people's care needs quickly enough. For example one person who required staff support to use the toilet was told they would have to wait. This person told us, "There was a time when we had great care from Creative Support. They made sure people were involved. Now it has changed and people are left waiting in their rooms to come down, sometimes staff can't be bothered".

We saw through our observations, and what people told us that the regular staff were caring and compassionate however this was not consistent with what we observed and what people told us about the agency staff. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

All the people we spoke with made positive comments about their regular care workers and were satisfied with the quality of care they were receiving from them. However, when people were not being supported by regular workers they expressed concerns about the standard of care that was being provided. Their comments included: "they don't understand me, they don't know what they are doing" and "I am supported by people that I have never met before, they are strangers, it worries me."

During our inspection there had been an incident involving regular care staff and a family member who had become upset about the use of agency staff to support their relative. The regular care staff had been subject to this person's frustration which had left them [care staff] feeling upset and angry. They told us " We try our best, we really do, we can't be everywhere at once." A person who used the service said, "I understand why they [the family] are upset but it's the staff that get the complaints, the manager does nothing to sort it out".

On the ground floor at Elkin Court there was a shop, a café and a communal lounge area. People told us they enjoyed taking part in the activities which were arranged. They told us these activities were arranged by the social committee, who were the people living at Elkin Court, not Creative Support.

We observed people who were more independent and less reliant on staff were more positive about their experience of living at Elkin Court. One person told us, "I like it here, I can come and go, it's easy for me".

We spoke with one person who was an active member of the social committee. They told us they ran a chair based fitness programme called healthy hips and hearts which they did with other people living at Elkin Court. They told us it had proven very popular and Creative Support staff had originally facilitated this but had since been told by Creative Support they were not allowed to do it unless it was in their own time. They had then carried it on. This was confirmed by the registered manager.

There was also a weekly quiz and bingo organised by the committee which people enjoyed. At the time of our inspection there was bingo taking place in the lounge area. We observed people enjoying the experience and family members were encouraged to join in.

We spoke with the registered manager about any events or activities for people using the service. They told us about a nostalgia day they had organised in which staff and people using the service were encouraged to dress up in 1940's clothes. We saw photographs which showed us people enjoying the day. The registered manager told us they were planning to source dementia training for staff as they recognised more people using the service may be living with dementia.

We found there were no robust arrangements in place to ensure agency workers were introduced to people and given time to read people's care plans. We were shown a checklist given to agency staff when they began work which they would tick when they had done. Given the amount of information contained within the care plans, most of which was out of date, it was evident these forms were being completed as a formality rather than as a measure of how much knowledge staff had acquired to enable them to support people effectively.

Details of the provider's complaints process had been included in a file in the entrance to the service. It was out of date and did not direct people on how or who to complain to.

People we spoke with said they had spoken with the senior support worker about their concerns but they said nothing seemed to have been done. For example, people had asked to receive support from regular staff. This had been logged by the senior support worker but was not being adhered to in practice.

Care records showed that people had a written plan in place. We found people's care planning could be more person centred. There was not an account of the person, their personality and life experience included in their plans.

We looked at an extra care assessment tool that had been sent to the local authority to inform that a person's needs had changed. An extra care assessment tool was used by the service to inform the relevant assessment and care management team from the local authority of a change so appropriate action could be taken by that authority. The registered manager told us that sometimes the care hours were cut as a result of a reassessment rather than increased. We discussed with the registered manager the

Requires Improvement

Is the service responsive?

importance of being clear about the level of service they were able to provide to each person and what action they would take if they felt a person was at risk as a result of a reassessment.

We spoke with the registered manager who told us that they needed to do more to improve the communication between them as the registered manager and the people who used the service.

Inadequate

Is the service well-led?

Our findings

All the people we spoke with told us they were not aware of who was in charge of the service, comments included, "We don't know who is in charge, and we never see the manager, have they left?"

We found the registered manager had not been present at the service for a number of months due to them being the registered manager at another service within the company.

We had received some feedback from the local authority that the registered manager was often absent at the service which made it difficult for them to access information when they needed it. They told us this had improved with the introduction of a senior member of staff.

We found audits which had been done were incomplete or out of date. For example the most recent management check done by the senior support worker was on 28 February 2015. A management check is done to check the performance of staff, the quality of service being provided and an audit of records. We asked the registered manager for the three audits before that so we could track any progress. The registered manager was unable to locate this information. We requested they send it on to us after the inspection. We did not receive the information.

We found on the day of inspection the registered manager was unable to locate some of the information we asked for. Information requested was not always readily available due to poor filing systems and storage. The senior staff told us this was something they were currently looking at improving.

We found staff were not being given specific time to complete care plans. This had been identified at the audit on 28 February 2015.

We asked the registered manager and the service director how this information was shared to ensure management maintained an overview of what improvements were needed in the service. We were told it would be discussed through supervision. We found this to be an ineffective way of monitoring quality of the service. We were also told no quality audits or spot checks were carried out above manager level by senior staff within the organisation. Information was not being collated or analysed to identify good practice or improve the service provided.

We found the service had not actively sought people's and/or relatives or their representative's views effectively. Staff performance was not being monitored effectively. Communication logs, medication administration records and financial transactions forms were not audited unless a concern had been raised. This meant people were at risk of receiving unsafe care and support as mistakes and/or poor care was not being identified or routinely analysed by the service.

The service had not held regular staff meetings with care workers. We saw one had taken place in February 2015 but there was no record available of one before that. Staff meetings ensure that key information from all aspects of the service is gathered and shared in order to enable the service to continually improve and reduce the risk of unsafe care and support.

We found that the registered person had not protected people against the risk of inappropriate or unsafe care. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People were not protected against the risks of inappropriate or unsafe care or treatment because the provider did not have effective systems to monitor the quality of the service provision.**

Regulated activity	Regulation
Personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.**

Regulated activity	Regulation
Personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The care and treatment of service users did not meet their needs, or reflect their preferences and was not person centred.**

Regulated activity	Regulation
Personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **We found that people's health, safety and welfare had not been safeguarded because there was not sufficient numbers of suitably skilled and experienced staff.**