United Response

United Response - 85 St Anne's Road East

Inspection report

85 St Anne's Road East
St Anne's-on-Sea
Lancashire
FY8 3NF

Website: www.unitedresponse.org.uk

Date of inspection visit:
25 February 2016

Date of publication:
07 June 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

United Response – 85 St Annes Road East is a small care home registered to provide care and accommodation for up to six people. The home is located close to St Annes town centre and a variety of local services and amenities. Each person has their own bedroom and shared communal facilities. The registered provider is the national charitable organisation, United Response.

There were five people who used the service at the time of the inspection.

The service was last inspected on 30 April 2014 and was found to be compliant in all the areas assessed.

This inspection took place on 25 February and 8 March 2016. The first day of the inspection was unannounced. The inspection was carried out by an adult social care inspector.

A new manager was appointed to the service at the time the inspection took place. The new manager advised us that they intended to apply to the Care Quality Commission to be registered as a manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service had experienced significant changes in the management team due to the appointment of the new manager and a new area manager at the same time. We found during this inspection that the service had lacked leadership for some time and as a result, some aspects of staff support such as team meetings and individual supervisions had fallen behind.

Procedures to check the safety and quality of the service had not been properly utilised and as a result, opportunities to identify and address areas for improvement had been missed.

We found that the service was not working in accordance with the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards legislation. This meant the rights of people who did not have capacity to consent to any aspects of their care or support may not be fully protected.

The management of medicines was found to be generally satisfactory. However, we noted improvements could be made in relation to medicines records and auditing. We made a recommendation about this.

People we spoke with expressed confidence in the service and spoke highly of the staff team. We noted there had been an increased use of agency staff over recent months, which was potentially detrimental to the consistency of care received by people who used the service. However, this issue had been identified by the new management team, who were taking steps to address it.

People were supported to access health care when they required it. Staff had a good understanding of people's needs and the support they required.

People we spoke with felt their loved ones were treated with kindness, dignity and respect. People led full and active lives and were supported to take part in activities they enjoyed, both inside and outside the home.

Staff were carefully recruited and provided with training that assisted them in meeting the needs of people they supported. Staffing levels at the service were calculated in line with the needs of people who used the service and were adequate to meet their personal and social needs.

People felt able to express their views and raise concerns about their care, or the service as a whole.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to consent and good governance.

You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The management of people's medicines was generally satisfactory but improvements were required in relation to medicines records and medicines audits.

Staff had a good understanding of people's needs and the action required to keep them safe.

People received their care from carefully recruited staff.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The rights of people who did not have capacity to consent to their care were not fully protected because the service was not working in accordance with the Mental Capacity Act 2005.

People's health care needs were carefully assessed and managed in partnership with community health care professionals.

Staff were provided with training to help ensure they had the skills to care for people in a safe and effective manner.

Is the service caring?

Good

The service was caring.

People's care was planned in accordance with their personal needs, wishes and the things that were important to them.

People were treated with kindness and respect and their privacy and dignity was consistently maintained.

Is the service responsive?

Good

The service was responsive.

Care workers understood people's needs and the support they required.

People were supported to lead active lives and take part in activities of their own choosing.

People were enabled to express their views and make decisions about their own care and the service as a whole.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Processes for monitoring quality and safety across the service had not been used effectively. This meant that opportunities for improvements had been missed.
However, the new management team had started to identify areas for improvement and were able to provide evidence that they were taking steps to address them.

United Response - 85 St Anne's Road East

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 25 February and 8 March 2016. The first day of the inspection was unannounced. The inspection was carried out by an adult social care inspector.

Prior to our visit, we reviewed all the information we held about the service. The provider was not asked to send us a provider information return (PIR) on this occasion. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we met all the people who used the service, and three relatives. We spoke with six staff members, including the newly appointed manager, newly appointed area manager and four care workers. We contacted three community professionals and asked them for their views about the service as well as local authority commissioners, but did not receive any feedback.

We closely examined the care records of three people who used the service. This process is called pathway tracking and enables us to judge how well the service understands and plans to meet people's care needs and manage any risks to people's health and wellbeing.

Throughout our visit we carried out observations, including how staff responded to people and provided support. We observed daily activities being carried out and viewed all areas of the home.

We reviewed a variety of records including some policies and procedures, safety and quality audits, four staff personal and training files, records of accidents, complaints records and various service certificates.

Requires Improvement

Is the service safe?

Our findings

Relatives of people who used the service told us they felt their loved ones received safe care. One person told us they did a lot of travelling and commented they never had any concerns about being away, as they had confidence in the service to provide safe care. Another person commented, "I have absolute confidence that [name removed] is in safe hands."

We saw when viewing people's care plans that risks to their health, safety and wellbeing were considered and where appropriate, there was guidance in place for staff about how to maintain people's safety. Risk assessments viewed included those in relation to specific medical conditions such as epilepsy, or those around specific activities like swimming or accessing the local community.

Staff spoken with were aware of risks to people's wellbeing and also aware of their responsibility to protect people who used the service from all types of abuse and improper treatment. Care workers were fully aware of the action they should take in the event they were concerned about a person's wellbeing and who to report such concerns to. Staff were also aware of the provider's whistle blowing policy and told us they would feel confident in using it if they had any concerns. Records viewed confirmed that all staff who worked at the service had received training in the area of safeguarding and that this training was regularly updated.

We looked at how the service managed people's medicines. We found that medicines were appropriately stored and well organised. Products with a limited shelf life were dated on opening to help ensure they were disposed of within the correct timescales. However, we noted that there was no separate facility for storing any items requiring refrigeration and current arrangements consisted of a locked box within the general refrigerator of the home. We advised the manager to carry out a risk assessment to ensure this arrangement was adequate.

Medicines records included guidance for staff about safe working practices and a sample signature sheet of all the signatures of staff who administered medicines within the home. We were able to confirm that staff were only permitted to administer medicines when they had received the appropriate training.

MARs (Medicine Administration Records) were in place for each person who used the service. In addition, a record including the person's photograph, allergies and any specific requirements in relation to support to take medicines, was in place. MARs were generally well detailed and completed to a satisfactory standard. However, we saw some examples where further information would have been useful, in relation to topical applications such as creams or ointments. We saw examples where people's MAR stated 'as directed' for creams and there was no further information available to guide staff about its application. This was discussed with the manager who advised us she was in the process of implementing Topical Application Charts which would include body maps and clear instructions about when and how to apply such treatments.

Some people who used the service were prescribed certain medicines on an 'as required' basis. Where this was the case, there was individual guidance for each person, which helped ensure they received their

medicines when they needed them.

One person who used the service and who had Epilepsy was prescribed a rescue treatment, which was to be administered by specialist technique in the event they experienced a seizure for a dangerous amount of time, or a number of seizures in a short space of time. We were able to confirm that all staff who worked at the service on a permanent basis, had received training in the administering of this treatment and had their competence regularly checked to ensure they were able to administer the treatment safely.

All staff members we spoke with showed a good knowledge of when they would need to administer the rescue treatment and confirmed they were confident to do so. However, we found that written information was confusing and in some parts of the person's care plan it conflicted. In one part of the person's care plan the wrong treatment was noted. This was pointed out to the manager who advised us she would rectify it immediately.

We found that some parts of the medicines records at the service were in a scruffy condition. Some were ripped and partly falling out of the medication file. This meant there was a chance that the information could be lost and not be available for staff when someone needed their medication. The manager told us she would ensure the records were renewed and properly maintained in the future.

We carried out some checks of loose boxed tablets against the records held in the home. In all cases the amounts held were found to be correct, indicating that staff managed people's medicines carefully and administered them at the correct times. However, we noted that some balances of stocks were not routinely carried forward when new stocks were received, which meant they were not fully auditable.

There was no evidence that regular audits of medicines and medicines records were carried out. This meant that mistakes may not have been identified and rectified quickly. This was discussed with the manager who advised us she would be implementing a medicines audit system with immediate effect.

There was a health and safety file held in the home, which detailed various safety checks carried out by staff on a regular basis. These included checks in areas such as checks on facilities and equipment within the home, like electrical equipment and emergency lighting, which were conducted on a regular basis. This helped to protect the safety and wellbeing of people who used the service.

Through viewing rotas and through discussion, we were able to confirm that staffing levels at the service were adequate to meet people's personal care needs and to ensure that people had regular support to carry out activities of their choosing in the community.

We looked at a selection of staff personnel files. We found there were robust recruitment processes in place, which helped to promote the safety and wellbeing of people who used the service. In all the files we viewed, we saw evidence that appropriate background checks had been completed including a full employment history, and a DBS (Disclosure and Barring Service) check, which would show if a person had any criminal convictions or had ever been barred from working with vulnerable people. However, we noted that some of the DBS checks (or CRB checks – as were prior to April 2015) were several years old. We discussed this with the manager and asked her to clarify the organisation's policy on DBS renewal.

It is recommended that the service's medication policy and procedures be reviewed to ensure they are in line with the NICE guidance, 'Safe Administration of Medicines in Care Homes.'

Requires Improvement

Is the service effective?

Our findings

People we spoke with expressed satisfaction with the health care their loved one's received. One person told us, "They always get the doctor if there is anything not right and they let me know straight away."

People's care plans contained a record of professional visits, which provided evidence that they were supported to access community health care when they needed it. We saw evidence of involvement of professionals such as GPs, dieticians and mental health workers in people's care plans.

Each person who used the service had a Health Action Plan (HAP) in place. This detailed their medical history and any medical conditions they had. The HAPs, which were in part completed in pictorial, easy read formats, detailed both specific and routine health care support required.

The support people required to maintain good nutrition and hydration was detailed in their care plan. We viewed the care plan of one person who had experienced weight loss over recent years. We saw that this had been identified and the advice of community professionals sought to ensure they received the support they required. We also viewed the plan of another person who had been underweight and had achieved a steady gain back to a safer weight.

People's food likes and preferences were noted in their care plans. We saw that weekly menus were in place to help ensure people received a varied and balanced diet. However, during the visit we heard one person who used the service say on several occasions that they did not want the meal, which was due to be served in the evening. Several staff members heard the person say this, but did not offer an alternative. The inspector spoke with the person and asked them what they would like instead and communicated their request to staff. It did not appear that staff would have acted on the person's request otherwise.

We discussed this issue with the manager who advised us they had identified improvements regarding how menus were to be developed, which would ensure people who used the service had greater choice about what they ate on a daily basis.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff spoken with demonstrated a good understanding of the MCA and DoLS. However, they were unable to confirm if any people who used the service had a DoLS authorisation in place or whether applications had been made. Each person who used the service was supported on a 24 hour basis including when they were out in the community and there was a key pad on the front door. This indicated that DoLS authorisations may be necessary and it was of concern that staff were not aware if they were in place.

We found some best interest decisions had been made on behalf of people who used the service relating to medicines management and health care. The records of these decisions stated that the people they related to did not have capacity to make the decisions. However, we could not find any mental capacity assessments to confirm this information.

These finding demonstrated a breach of regulation 11(1)(2) &(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed practice in relation to the MCA and DoLS with the new manager and new area manager. They advised us they would take steps to immediately clarify the situation in terms of DoLS applications, authorisations and mental capacity assessments and ensure the necessary steps were taken.

In discussion we were advised that there had been some shortages on the staff team recently due to several care workers being on long term leave. We were advised this had led to an increased use of agency staff in recent months. We saw when viewing the care plan of one person that the use of agency staff was a known trigger for anxiety and distress. We discussed this issue with the new manager who was able to provide evidence that she has identified this issue and had taken steps to address it. These steps included agreement from the organisation to recruit additional, permanent staff members.

There was a comprehensive training programme in place, which all staff were expected to complete. This programme included courses in important health and safety areas, such as moving and handling and infection control. In addition, staff were provided with training that related to the needs of the people they supported. For example, training in areas such as caring for people who lived with dementia or autism.

Training was regularly refreshed to ensure that staff were supported to update their skills and knowledge on a regular basis. We saw that the new manager had completed a training audit and had made arrangements to ensure all staff would receive their refresher training within appropriate timescales.

Approximately half the staff team held nationally recognised qualifications in social care. Other staff members were in the process of obtaining these qualifications.

Staff usually received formal supervision on a two monthly basis. However, we saw that in recent months this had not always been achieved and some supervisions had fallen behind. The new manager had identified this as part of the training audit and was taking steps to address it. She had also developed a supervision matrix to enable her to monitor the frequency of people's supervision effectively.

Good

Is the service caring?

Our findings

We received positive feedback from people we spoke with about the way they, or their loved ones were cared for. People's comments included, "I couldn't wish for better people to be looking after [name removed]." "They all seem very caring. I've yet to come across one [staff member] that I'm not 100 percent happy with." "It is a very homely place and it has a real family feel." "I have never had any concerns about the staff. They are all very caring."

All the people who used the service had done so for several years, some for over twenty years. There was a stable group supported by some staff members who had also worked at the service for many years. This meant people had the opportunity to develop relationships and carers had a very good understanding of the people they were supporting.

We observed people interacting with staff and receiving support. Our observations were very positive. It was apparent that people who used the service shared positive relationships with the staff and we saw lots of good humoured chatting and interaction.

We saw that people were supported in a kind and patient manner and at their own pace. Staff approached people in a respectful way and ensured their dignity and privacy was promoted.

Care workers spoke about the people they supported in a caring and respectful manner. They demonstrated an in-depth knowledge of people's needs and the support they required and showed genuine concern for their wellbeing.

People's care plans contained a good level of detail about the things that were important to them and how they wanted to be supported. We also noted that their care plans addressed the importance of preserving their privacy and dignity during personal care.

Family members we spoke with told us they felt able to visit at any time and said they were always made to feel welcome. One person commented, "I feel involved in everything. They are very welcoming of me and my ideas."

Good

Is the service responsive?

Our findings

Everyone we spoke with expressed satisfaction with the service provided. People's comments included, "I could travel the length and breadth of England and not find a better service." "I think they provide a marvellous service." "I am completely satisfied. I couldn't find fault if I tried." "I think they [the staff] go above and beyond."

Each person who used the service had a comprehensive care plan in place. We viewed a selection of people's care plans and found they contained a great deal of information about all aspects of their daily lives. A social history was included that gave the reader an insight into the person, their background and important relationships.

Activities of daily living were covered in people's care plans and included areas such as personal care and dressing. There was a detailed medical history and Health Action Plan in place for each person. People's hobbies and valued pastimes were also well detailed and any risks to their health and wellbeing were addressed with relevant guidance in place for staff about how to support people safely.

There was a detailed section in each person's care plan about their individual methods of communication. For example, if the person communicated with none verbal gestures, these were described. Also included, was information about how the person might attempt to communicate something such as, 'when [name removed] is happy they do this'. This information helped support staff to understand the people they were supporting and to help them express their choices.

We saw some good examples of care planning that was centred on the individual needs, preferences and wishes of the person. For example, clear details about their preferred daily routines and how they liked to spend their time.

We noted that the care plans were very lengthy documents that would take carers some time to read, or locate specific information. On that basis, we discussed the benefits of introducing a one page profile and clinical alert sheet for each person so that the information would be available at a glance. This was something the manager was keen to action.

We saw that people's personal wishes were taken into account when planning their care and the relatives we spoke with all told us they felt they had the opportunity to be fully involved in their loved one's care. One person said, "They keep me involved with everything - they always ask my opinion about things."

Lifestyle support around activities and hobbies was a large feature of people's care plans and we could see that people who used the service led busy and active lives. On the day of the inspection, several people who used the service were enjoying days out, as we were told, they regularly did. One person told us he had been out on a train journey, which was one of his favourite things to do. Another person was looking forward to a trip to Blackpool to visit his favourite pub and fish and chip restaurant. This person was also looking forward to appearing in a show, which was planned with a local dance and drama group he attended.

A relative we spoke with was very complimentary about the way in which their loved one was supported to enjoy their hobbies and pastimes. They said, "They [the staff] are always trying to think of new things. They have some lovely ideas and [name removed] really enjoys trying things out."

Another relative explained that their loved one preferred to spend most of their time indoors. They explained that care workers had tried many new ideas, but their relative just preferred their own home environment. They were very pleased that their loved one was provided with an additional living room within their home, so they had extra space to spend their time.

Each person who used the service had been provided with an Individual Charter which gave them information about what they could expect from the service. This was produced in a pictorial, easy read guide and contained information such as, 'we will support you to do the things you enjoy doing' and 'other people can only come into your private room if you invite them – unless we need to help you quickly.'

There was a pictorial complaints procedure available which provided guidance about how to raise concerns and what to expect in that event. All the people we spoke with told us they were fully aware of how to make a complaint and would be comfortable in doing so. However, no person we spoke with had felt the need to make a complaint in the past.

Requires Improvement

Is the service well-led?

Our findings

There was a new manager in post at the time of the inspection who was still going through an induction. A new area manager had also been appointed, which meant there had been significant changes to the management of the service.

People we spoke with were aware of the new structure and told us they were pleased the management team had been appointed. One person told us they felt the home had lacked leadership for some time. This information was supported by some of our findings during this inspection.

Staff supervisions and team meetings had not been occurring regularly for some months. This was of concern particularly as a community professional involved with the care of one of the people who used the service had stressed the importance of the staff team meeting on a regular basis to discuss approaches and strategies in relation to the person's support.

We were advised that there had been a high use of agency staff in recent months. This had been due to the usual staff team being depleted. However, some staff we spoke with felt the situation could have been managed better, for example by attempting to arrange regular agency staff.

We did note however, that the incoming manager and newly appointed area manager had identified many of the issues we found and had started to take steps to address them. For example, a team meeting and individual staff supervisions had been arranged.

There was an audit system in place designed to ensure regular monitoring of quality and safety throughout the service. These included checks in areas such as care planning, recruitment and staff training. However, we found that the audit schedule had not been fully completed and some checks had not taken place for several months.

Other quality assurance processes such as monthly quality visits from an area manager and peer inspections from other managers from the organisation, had also fallen behind in recent months.

Some daily checks were conducted, such as those relating to people's finances. However, there was no evidence that medicines audits took place on a regular basis. This meant there was a risk that mistakes may go unnoticed and opportunities to rectify them could be missed.

It was not clear if the system in place across the organisation to monitor adverse incidents, such as accidents or safeguarding concerns had been properly utilised over recent months. The new manager was unaware if this was the case due to them being very new in post and there was no documentary evidence to support the regular reporting and monitoring of such incidents by the provider. This meant that opportunities to identify themes or trends and as such take action to improve the safety and quality of the service, could have been missed.

The above findings demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed the failures in relation to governance with the new manager and new area manager, who acknowledged improvements in the monitoring of safety and quality were required. They were able to give us examples of measures they had started to take to ensure these improvements were made and to ensure the service benefited from good quality leadership in the future.

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
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was failing to ensure people's rights were protected because staff were not working in accordance with the relevant legislation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement effective arrangements to monitor safety and quality across the service.