CareTech Community Services Limited

CareTech Community Services Limited - 34 Porthill Bank

Inspection report

34-36 Porthill Bank
Porthill
Newcastle Under Lyme
Staffordshire
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Tel: 01782612223

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27 June 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on the 27 June 2016 and was unannounced. At our previous inspection in 2013 we had no concerns in the areas we inspected. At this inspection we had concerns that the service was not safe, effective, caring, responsive and well led. We fed back our concerns to the provider and reported them to the local authority. We have judged this service as Inadequate and placed it into 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months.

34-36 Porthill bank provides accommodation and personal care to up to six people with a learning disability, autism and associated challenging behaviours. At the time of the inspection six people were using the service.

There was no registered manager. The manager had recently left prior to registering with us. 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.'

People who used the service were not safeguarded from abuse as incidents of abuse had not been reported to the local authority for investigation. Some incidents of abuse had not been recognised and no action had been taken to minimise the risk of further incidents.

There were insufficient suitably experienced staff to safely meet the needs of people. Care staff were being required to provide one to one care to people and complete management duties.

The provider had recruitment procedures in place although we were unable to clarify if appropriate references had been gained prior to employment.

Risks were not reviewed and assessed to ensure that risk of harm to people were minimised following incidents of harm.

People did not always receive health care support in a timely manner. When people complained of being unwell support was not always gained.

People were supported to maintain a healthy diet.

Staff did not feel supported to fulfil their role effectively and had received no formal supervision or competency checks.

The provider did not consistently follow the principles of the MCA 2005 to ensure that people consented to or were supported to consent to their care, treatment and support.

People were not always treated with dignity and respect. Care staff lacked clear leadership and a culture of poor staff practise had developed.

Staff did not always have the information they needed to be able to meet people's individual needs. People did not always receive care that personalised and met their individual preferences.

Complaints were not always taken seriously and acted upon. Not everyone had confidence in the provider to deal with the complaints.

The systems the provider had in place to monitor the service were ineffective ad people were receiving care that was Inadequate.

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

The service was not safe.

People were not safeguarded from abuse as local safeguarding procedures were not being followed when there had been an incident of abuse.

Risks were not always minimised following incidents that had resulted in harm to the person.

There were insufficient suitably trained staff to safely meet the needs of people who used the service.

People's medicines were not managed safely.

Is the service effective?

Inadequate

The service was not consistently effective.

People did not always get the health care they required in a timely manner.

Staff were not supported to fulfil their role effectively.

The principles of the MCA were not consistently followed.

People were being lawfully restricted of their liberty.

People were supported to maintain a healthy diet.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respect.

People's right to privacy was upheld.

People were as involved as they were able to be in decisions about their care, however their choices were not always respected.

Is the service responsive?

Inadequate

The service was not responsive.

People did not always receive care that met their individual needs and reflected their preferences.

Complaints and feedback were not always listened to, respected and acted upon.

Is the service well-led?

Inadequate

The service was not well led.

There was no clear, visible leadership at the service.

Staff morale was low and they felt unsupported.

Systems the provider had in place to monitor the quality of the service were ineffective.

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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 27 June 2016 and was unannounced. It was undertaken by one inspector.

We had received information of concern prior to this inspection about the management and safety of people who use the service.

People who used the service were unable to tell us about the care they received, so we spent some time in the communal area observing their care. We spoke with a relative, the locality manager, team leader and three members of the care staff team. We spoke with a social care professional and the commissioners of the service. Following the inspection we raised safeguarding referrals for all of the people who used the service as we had concerns about people's safety.

We looked at the care records for three people who used the service and the systems the provider had in place to monitor the service. We looked at people's medicines and records of incidents that had taken place at the service.

Inadequate

Is the service safe?

Our findings

People who used the service were not safeguarded from abuse or the risk of abuse as when incidents of abuse had taken place these had not been reported to the local safeguarding authority for further investigation. We looked through records and saw that there had been several assaults on people who used the service by other people who used the service. No action had been taken following these incidents to investigate or minimise the risk of further incidents. This meant that people who used the service were being abused and this was not being investigated, people continued to be at risk of harm from further assaults and no action had been taken to mitigate the risks.

These issues constitute a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service were not receiving care and support that was safe. All of the people who used the service had one to one staff due to their assessed needs and associated challenging behaviours. On the morning of the inspection we found one member of staff eating their breakfast in one room whilst the person they had been allocated to care for was wandering around the service unsupervised. This person was at high risk of self-injurious behaviour and their care plan stated they should have staff present with them all day. We saw records that confirmed that there had been incidents of self injurious behaviour since they had been at the service. This meant that this person was at risk of harm as they were not receiving the staff support they had been assessed as requiring.

We saw that another person was left unsupervised in the dining room whilst a member of staff prepared them a snack. This person required supervision and was assessed as requiring one to one staff at all times during the day. We saw records that confirmed the person who was wandering around on their own had been assaulted by the person left in the dining room. This meant that these people were at risk due to staff not following their risk assessments and ensuring they had the supervision they required.

Staff told us that they did not feel there was enough staff to meet people's assessed needs safely. We found that there were six staff on duty all providing one to one care. We saw from rotas and the latest quality review that this was the usual staffing levels. One of these staff was also the senior person who was responsible for administering medication and coordinating the shift including answering the phone so they were not able to provide the one to one support the person required. Some people required two to one staff support when accessing the community and this was not always available to them. We spoke with a relative and a social care professional who confirmed that people were not getting the required amount of staff support they needed.

This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked to see if people's medicines were managed safely and found that one person did not have their prescribed medication in stock. The medicine was to support the person when they became anxious and

agitated and was prescribed to be given when required. Staff could not tell us why the medication was not in stock and how long it had not been available for the person. This meant that this person was at risk of harm if they became agitated as they did not have the medicine they needed to help them when feeling anxious. We discussed this with the locality manager who told us they would order the medication that day.

We saw that another person had been administered their anti-anxiety medication at times when they had not been anxious. It had been administered to prevent anxiety prior to an activity. This had not been discussed and agreed as in their best interests. This meant that this person was not receiving their medicine in the correct way or at the prescribed times. The provider was not following relevant legislation and guidelines and this person was being given their medication inappropriately.

Risk assessments and behavioural management plans were in place for people; however staff did not always follow them or know them. We were made aware of one person whose anxiety had risen to a level that staff could not manage and an outside agency had become involved to support the person. Staff we spoke with told us they had not been given sufficient information to be able to support this person and the person had not had a period of transition. The locality manager agreed that this was the case, however we could not see what lessons had been learned from this incident to prevent it from happening again. Staff we spoke with told us there had been no debrief following the incident and they had felt unsupported throughout and after the incident.

We saw one person becoming slightly anxious and raising their voice. The member of staff supporting them said: "Stop shouting", and "Stop grabbing", when they appeared to grab out. We looked at this person's risk assessment and saw that it was clearly recorded that this person had specific ways in which they required redirection and this was not how we observed them being cared for.

We saw in another person's behavioural management plan that they may become anxious if the member of staff allocated to them used the telephone. We saw that the person was being supported by a member of staff who was responsible for making and receiving phone calls and we saw they were receiving calls throughout the day. The member of staff was not aware of this risk until we pointed it out to them. This meant that people's risk assessments were not being followed to prevent harm and keep people safe.

Incidents of restraint were not always monitored to ensure they were appropriate and proportionate. Incident reports were completed by staff, however some incidents of restraint lacked detail of who was involved and how long the incident had taken place for. No debriefs took place with the staff involved to discuss the incident and identify ways to minimise the risk of further incidents. This meant that people continued to be at risk as lessons were not being learned to reduce the risk of further similar incidents.

We found that risks associated with staff's welfare had not been put in place to protect them from harm. One member of staff was at risk if a person who used the service attempted to assault them due to a medical condition. There was no risk assessment in place for this member of staff to prevent harm and injury.

These issues constitute a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were not able to see if the provider followed safe recruitment practises as staff recruitment files were in a locked filing cabinet and the key was not on the premises. Following the inspection the locality manager sent us two staff proformas which documented that these staff had been checked to ensure that they were suitable to work with people who used the service.

Inadequate

Is the service effective?

Our findings

Staff told us they did not feel supported and that staff morale was low. They told us they had not received any formal support and supervision and that the manager who had recently left had also been unsupported. One member of staff told us: "There used to be a manager, deputy and two team leaders and now there is just the manager and now they have left".

Some staff had not received training to meet the needs of people who used the service. One member of staff told us that had completed an induction and restraint training but had received no other relevant training. The locality manager sent us a list of training following the inspection which included valuing people and caring for people with autism. However from our observations and looking at records, staff competencies and their level of understanding of the training had not been assessed. We observed and saw records that confirmed poor practice for example, not all incidents of restraint were recorded and poor terminology was used to describe people and events which meant that people were written about in a undignified manner.

Care staff were expected to be shift leaders and administer medicines and manage the shift including making and receiving phone calls and dealing with any onsite emergency as it happened. The staff told us they had received no extra training to fulfil this role and there was no monetary reward. We saw that staff regularly got assaulted by people who used the service and staff told us they were not offered any support following the incidents.

People received support from other health care agencies, however advice and guidance was not always followed to ensure that people's mental health needs were met. Care plans to support people when they were anxious were not always followed and one person did not have their prescribed medicine available to them if they required it as it was out of stock.

We saw that one person had been administered pain relief regularly for a month for a pain they were complaining of. No medical support had been sought to identify the cause of the pain and the person continued to complain. This meant that this person's health care needs were not being met as appropriate treatment had not been sought in a timely manner.

These issues constitute a breach or Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) was not being consistently followed to ensure that people were being supported to consent to their care and treatment. The MCA 2005 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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. For example, one person was being administered their as required medication to prevent anxiety and not as prescribed, this had not been agreed as in their best interests, the principles of the MCA were not being followed.

This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Deprivation of Liberty Safeguards (DoLS) are part of the MCA 2005. The legislation sets out requirements to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. We saw that everyone had been referred for a DoLS authorisation to ensure that people were being legally restricted of their liberty.

People's dietary needs were met. No one had a special diet however we saw that people were encouraged to maintain a healthy diet. We saw one person had a set 'snack' time and they had fruit, yoghurt and a fruit smoothie. People were regularly weighed to ensure a healthy weight. One person had been supported by staff to attend a slimming club and had been successful in losing weight.

Requires Improvement

Is the service caring?

Our findings

Although we observed some positive and respectful interactions between staff and people who used the service we also observed and saw recorded some poor practice and interactions. We saw that a member of staff had recorded that whilst on a community activity one person had picked up a leaf and had attempted to eat it. The staff member had recorded: "I thought it was a good lesson for [person's name] to learn themselves and eat the leaf". We saw another record that stated: '[Person's name] was told they could not watch a certain TV programme in the lounge but they demanded'. This showed that staff were not always treating people with dignity and respect.

We observed one person became anxious and we observed that the interactions between the staff member and person lacked empathy and understanding. We saw at one point the staff member blocked the person's way to prevent them from going into one area. The interaction between the staff member and person was cold and lacked any emotion. We checked to see if this was in the person's behavioural management plan and saw it was not.

On another occasion we observed a discussion about a planned outings, the staff member said to another staff member in front of the person: "If the car doesn't come back in time, 'they' can walk". Again the interaction was cold and lacked warmth and compassion.

These interactions and actions did not demonstrate that people were being treated with dignity and respect and constitute a breach of Regulation 10 of The Health and Social Care Act (Regulated Activities) Regulations 2014.

People had their own private rooms and some people had private living areas. We saw they had been furnished and personalised to respect people's personal preferences.

We saw that people who used the service were involved in making decisions about their care and support as much as they were able to be. The provider ran a service user forum where people could have a say about how the provider ran all their services. We were informed that one person who used the service at Porthill Bank had attended and appeared to enjoy it. We saw that one person had signed to agree to a care plan in relation to how much time they spent in bed. Another person had an advocate to support them when making decisions. This meant that people were being supported to make decisions about their care and support.

Inadequate

Is the service responsive?

Our findings

Prior to admission into the service an assessment of people's needs was completed, this was to ensure that the service could safely meet people's needs. However we were informed of a serious incident affecting one person following their admission. Staff, the locality manager, the person's social worker and relative told us that there had not been an effective transition period for the person. This had resulted in staff not having the information they needed to be able to support the person safely. The person had become unwell and emergency support had to be gained which had meant extreme action was taken. This would have been avoided if the staff had the information they needed to keep this person safe at identified times.

People's care plans and risk assessments did not always have the most up to date information within them. Regular reviews involving people and their representatives had not taken place. Two people had been using the service for six months, but the care plans in place were the plans from their previous service and had not been updated. There had been numerous incidents which had been recorded and sufficient time spent with the people and yet the plans and risk assessments had not been reviewed.

Staff did not always follow the care plans and risk assessments that were in place. For example, we saw one person's care plan stated that they did not like staff using the phone; the staff member supporting them did use the phone and was unaware of this care plan. We observed another person when anxious being supported in a way that was contrary to their care plans.

One person asked if we would save them some of our tea out of our cup, they became more forceful in their approach when continuing to ask. We asked the member of staff supporting them whether this was appropriate and within the person's care plan. The staff member told us: "Some staff do, some staff don't". We asked the staff member whether this meant that there was no consistency in the approach to this request, the staff member agreed. This meant that this person was not receiving care that was consistent and supported them to manage their autism.

People were offered opportunities to engage in in-house and community activities; however these did not always take place as planned. One person had been told they were going to the seaside on the day of the inspection, but this was cancelled on the day as staff told us it was going to rain, yet rain had not been forecast. We saw records that one person was 'told' they could not watch a certain TV programme in the lounge. A relative told us that their relative did not always get their allocated staffing hours to ensure that they accessed the community as often as they needed it; this was confirmed by the person's social worker.

This meant that people were not receiving personalised care that met their needs and individual preferences. These issues constitute a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the provider had asked relatives for feedback on the service in the form of a quality questionnaire in 2015. We saw that one relative had asked for the 'doorbell' to be fixed and another relative had noted that there was insufficient management support within the service. The feedback had not been

acted upon and both issues were evident on the day of the inspection. This showed that the provider was not responsive to people's comments and suggestions to improve the service.

The provider had a complaints procedure. However one relative told us that they did not feel their concerns and complaints had been taken seriously. They told us that staff had said: "We are unable to speak to you", when they rang. The locality manager confirmed that not all complaints that came into the service were recorded and acted upon and they were unable to show us how any issues raised had made improvements to the quality of service being delivered. The providers arrangements to make sure that information and concerns received about the quality of care were investigated and recorded were not effective.

Inadequate

Is the service well-led?

Our findings

There was no registered manager at the service. The last registered manager had left in September 2015. The provider had appointed a new manager who had not registered with us and had recently left the service. The staff we spoke with told us that they felt that the manager had not been supported by the provider to fulfil their role as they had to manage with no deputy or team leaders. One staff member told us: "The people here we care for are very complex I don't think that it is recognised how complex and the manager required more support".

The service lacked clear visible leadership. Care staff were being asked to lead the shifts. Leading the shifts involved administering medication and making and taking phone calls and dealing with emergencies, such as gaining staff cover when required. Staff received no extra training for this role and no monetary reward. From our observations a negative culture had been formed within the service. This had been previously noted by a social worker and identified by the locality manager back in May.

Staff told us that staff morale was low and that they were not recognised or valued for the roles they undertook on a daily basis. Staff were receiving no formal support and supervision and their competency to compete their roles was not regularly assessed. We saw that staff were often assaulted and no support was offered following these assaults. Incidents of assaults and abuse were not being audited and monitored. The use of restraint was going unnoticed as although staff were completing the incident forms, no one was monitoring and analysing the use of restraint. This meant that the provider could not be sure that the restraint being used was appropriated and proportionate to the incident.

Records were not audited for their content and some records reflected a poor value base from staff, which if identified could have prevented poor practise. Incidents of abuse had been recorded; however they had not been noted and acted upon with referrals to the local safeguarding authority. Medication records were not audited and the medication ordering system was not effective as one person had no PRN medication in stock if they required it.

A quality audit of the service had been started but not completed in April by a compliance manager. The audit had not identified any of the issues within this report, such as staff not having had supervision with the manager, risk assessments not being updated, poor record keeping and a lack of clear leadership within the service.

The locality manager told us they had concerns raised to them by two visiting social care professionals and a health care professional in May. They had since been into the service and drawn up an action plan highlighting some of the areas we identified, however the action plan had not recognised significant issues within the service such as lack of safeguarding referrals being made and the use of restraint.

These issues constitute a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The previous manager had notified us of some significant events that had occurred, however not all notifications had been sent to us [CQC] as the provider is required to do. We had not been notified of a DoLS authorisation for one person who used the service.