Care Quality Commission

Equinox Care

Southampton Way

Inspection report

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Ratings

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

Overall summary

This unannounced inspection took place on 3 November 2014. The service was last inspected on 10 December 2013 when we found it met all the regulations we checked at that time.

The service provides care and accommodation for 13 people with mental health needs. Twelve people were using the service when we inspected it. Each person has their own bedsitter accommodation, which includes a bathroom and kitchen facilities. Downstairs the building has a large living/dining room, a kitchen and a staff office. At the time of the inspection, some people were independent and required minimal support from staff, for example, they prepared their own meals. Other people's needs were more complex and they required more support from staff to prevent a relapse of their mental health condition and to improve their quality of life.

At the time of the inspection the service did not have a registered manager in post but had a manager who was responsible for the day to day operation of the service. This person had been in post for three weeks prior to the inspection. The service should have a registered manager. This 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

Summary of findings

the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider advised us on 1 December 2014 they do not intend to seek a registered manager for the service as they have plans for major changes to the service from April 2015. Consequently, we are not taking action to ensure the provider appoints a registered manager.

People told us they were happy with the service and liked the staff who they said were caring and helpful. However, we found people were not protected from the risks of poorly maintained premises. Repairs to the premises were not carried out promptly and a number of required improvements to the decor and furnishings had been identified by the current manager of the service.

People did not always receive their medicines safely as prescribed. The provider had a system to audit the quality of the service but had not ensured action was taken to improve the service when problems were identified. Staff had not always accurately recorded whether people had received their medicines or not. A health professional told us the service had a proven track record of promoting people's health and worked openly and constructively with the Community Mental Health Team. However, full information about some people's individual needs and interests had not been obtained. Staff could not therefore effectively engage them in activities that met their needs and interests.

We found a number of breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the action we have asked the provider to take is detailed at the back of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Staff had not always completed people's medicines administration records correctly. People may not have received all their medicines safely as prescribed. People's health and safety was at risk because repairs to the premises were not carried out promptly.	**Inadequate**
Is the service effective? The service was effective. Staff were trained to carry out their responsibilities and meet people's needs. People told us staff asked them for their consent before they received their support. The service ensured people's health needs were met and they received food they liked.	**Good**
Is the service caring? The service was caring. People told us the staff were patient and kind. They said their privacy was respected. Staff had a good knowledge of people who used the service. We observed that staff were polite and friendly when supporting people.	**Good**
Is the service responsive? The service was not always responsive. People were not always asked about their interests so that staff could support them to pursue these and improve their quality of life. The service ensured people's support needs were regularly reviewed. People were given information about how to make a complaint.	**Requires Improvement**
Is the service well-led? The service was not always well-led. The provider did not have a sufficiently robust system to improve the quality of the service. Action was not promptly taken on issues identified for improvement. People were asked for their views of the service but it was not evident that they were asked about how they were treated by staff. A suggestion that people had made to improve the service was not followed up.	**Requires Improvement**

Southampton Way

Detailed findings

Background to this inspection

We carried out this inspection 3 November 2014 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. It was unannounced and carried out by one inspector. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Before the inspection we reviewed the statutory notifications we had received from the provider about incidents at the service. During the inspection we spoke with two people who use the service, the manager and two members of staff. We read information about the operation of the service and quality monitoring information.

We looked at three people's care records and their medication administration records. We reviewed two staff records which included information on recruitment, induction and training. We read reports undertaken by the provider on the quality of the service. After the inspection we spoke with a health professional from the Community Mental Health Team (CMHT) who was in regular contact with people using the service to obtain their view of it.

Inadequate

Is the service safe?

Our findings

The premises, which the provider rented from a housing association, were not safe and suitable for people. During the inspection we observed that in the living room, which was used by people to watch television and eat their meals, a leak from a water pipe had caused the plaster from the ceiling to come off. Water was dripping through the ceiling and was collecting in a bowl on the floor. The dripping water was close to an electric light fitting. Staff told us the situation had existed for the past five days. Records confirmed staff had been in daily contact with the landlord who was responsible for undertaking repairs about the issue. Although workmen had come to try and fix the problem it had not yet been resolved. The maintenance of the building was not of the required standard. This had resulted in risks to people's safety and well-being. The manager informed us two days after the inspection that the leak had been fixed

People's surroundings did not promote their well-being. The manager had recently undertaken a health and safety audit of the building. His report showed there were a number of outstanding repairs, such as non-functioning light fittings and unsuitable flooring in people's bedrooms. The report had also identified that the furnishing of people's rooms required improvement, for example new curtains and blinds were needed. At the time of the inspection it was unclear when these renovations and improvements would take place. On the day of the inspection part of the building had an unpleasant smell. We reported this to the manager who asked the service's cleaner to take action to address it. The provider had not protected people from the risks associated with unsafe or unsuitable premises. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Records showed fire drills had been carried out and heating and electrical systems had been appropriately checked and serviced.

People were at risk because the provider's arrangements for administering their medicines did not consistently ensure they received their medicines safely. We checked three people's medicines administration record (MAR) charts for the three weeks before the date of the inspection. On most days it was clear people had received all their medicines as prescribed and at the correct time of day because staff had signed their MAR charts. However, we found that on two people's MAR charts there were single instances where staff had not signed the MAR charts, or entered a code to indicate if the person had, for example, declined their medicines. In one of these people's daily records staff had recorded that the person had been given their medicines at the relevant time. In the other person's daily records there was no reference as to whether the person had received their medicines or not.

The service's most recent weekly audit of stocks of medicines showed another person had not been given all their medicines as prescribed, as one evening dose of their tablets was still in their dosette box. However, when we looked at the person's MAR chart a staff member had signed that they had received this dose. Staff were not completing MAR charts accurately, therefore we could not be certain people always received their medicines safely as prescribed. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Medicines were stored securely and checks were made to ensure medicines were stored at the correct temperature.

People told us they thought there were enough staff in the service. On the day of the inspection the number of staff on duty was in line with the staffing level set by the provider. One of the staff on duty was from the provider's 'bank' of staff. Staff told us unexpected staff absence was always covered by use of 'bank' staff.

The provider had ensured staff were suitable for their job role. We checked a permanent staff member's recruitment record. This confirmed the provider had obtained the necessary information about their background, qualifications and experience. References and a criminal records check had been obtained.

We checked three people's care records. Risks to people had been assessed and their support plan set out how these would be managed to minimise the risk of harm. People's support plans were regularly updated and risks were evaluated at regular care programme approach (CPA) meetings with community mental health professionals. Risk assessments included guidelines for staff in relation to preventing the deterioration of people's mental and physical health through the early recognition of signs and symptoms that people were becoming unwell. Staff we spoke with were well-informed about these guidelines and

Inadequate

Is the service safe?

explained how they were put into practice when supporting people. A health professional told us the service informed them promptly when there was a risk to a person's mental health in order that effective action could be taken. They said the service then followed the advice they were given.

People told us they felt safe at the service. They said staff treated them well and they had no concerns about bullying or harassment. A person said, "No, there's nothing like that going on here." Staff we spoke with were able to explain how they would recognise the signs of abuse or neglect. They knew how to report safeguarding concerns and how to 'whistle blow' if the provider did not take action to protect people from harm. Some people in the service received help to manage their money. They told us they had no concerns about this and said they were happy that their money was safe. Staff told us there were financial procedures in place to reduce the risk of financial abuse. They said managers regularly checked staff had appropriately completed financial records.

Good

Is the service effective?

Our findings

People who use the service told us they were free to come and go from the service as they wished. A person said, “I can go out when I want, I will probably go out after lunch. If you want to be out late it’s no problem.” During the inspection people went in and out of the building. Care records showed people were involved in making decisions about all aspects of their lives. Another person told us, “[The staff] cannot do anything without my agreement. I know that. Things are always discussed with me.”

Staff we spoke with understood the principles of the MCA in relation to presuming people’s capacity to make decisions. They also understood that if people did not have mental capacity they could not be deprived of their liberty without a DoLS authorisation. Staff records had evidence they had completed on-line training on these topics.

A mental health professional told us people’s mental health needs were met. They said the service had a good track record in relation to supporting people with complex needs to keep as well as possible and keep out of hospital. During the inspection we observed that a person appeared physically unwell. Staff told us they were aware of this issue and said it was linked to their mental health needs. It was clear from the person’s care records that staff in the service had taken the appropriate steps to ensure the person’s health needs were urgently assessed by the CMHT. There was information in people’s files about their physical health needs. A person told us, “If I don’t feel well the staff would help me get to see someone about it.” People’s records showed they were supported to access their CMHT, GP and other services when required.

The provider had ensured staff had the skills and experience to meet the needs of people using the service. A member of staff told us they had a two week induction when they started work at the service. They said that during this period they had learnt about their role in implementing the provider’s procedures, read people’s support plans and observed more experienced staff delivering care and support. Their staff record included a report from their manager which confirmed they had observed their work practice and they had met the required competencies to work permanently at the service. This report included details of the training plan for the coming year. There was also evidence the member of staff had completed training in relevant subjects such as diversity and equality, personalised care and adult safeguarding.

Records of one to one supervision meetings between staff and the manager showed staff were given the opportunity to discuss people’s care and support. A member of staff told us the manager was available on site to give them advice whenever they required it.

People told us they were happy with the arrangements for get meals and refreshments. A person told us, “The food is alright here and we do get a lot of vegetables.” We spoke with the chef who told us people in the service agreed the menu in advance at a meeting. On the day of the inspection people were due to have a pasta bake. All the people we spoke with said they were happy to have pasta bake that evening. They said the food was tasty and they were happy to eat whatever was prepared. The manager said people did have the opportunity to prepare their own food in their rooms if they wished. Some people did this but they were not available for us to speak to during our visit.

Good

Is the service caring?

Our findings

People told us staff were respectful and polite to them. A person said, "I am treated ok and staff talk nicely to us." Another person told us, "The staff are very pleasant. I get on with everyone here." We observed staff were patient with people, listened to what they had to say and responded to their questions in a friendly way. For example, when a person asked a staff member about a health appointment staff explained the proccess in a way that reassured the person and reduced their anxiety.

A health professional told us they had always observed staff to be kind and caring towards people. A member of staff told us they had read about people's background in their care records and this helped them to understand people's diverse needs. For example, they said some people in the service required very little support from staff because their mental health had improved. They told us some other people were currently unwell and needed more support, particularly in relation to managing their medicines and attending appointments with health professionals.

At the time of the inspection the provider had started a project to substantially change the service. They had made arrangements for an independent advocate to meet with each person to explain the process, how it would affect them and to support them to make decisions about their future. People we spoke with said staff had started to talk to them about the proposed changes and any worries they had.

People told us they were involved in meetings to discuss their care and made decisions about how they spent their time. They said they could go in or out of the service as they pleased and spent time in their own room or downstairs. People said their private space was respected and staff asked them if they could come into their room. We observed people's care records were kept securely. A member of staff explained to us they were trained to treat people with respect, records of their induction to the service confirmed this. We observed a staff handover between shifts. Staff spoke sensitively about people and their needs. The meeting was held in the staff office and there was no risk that confidential information could be overheard.

Requires Improvement

Is the service responsive?

Our findings

People attended Care Programme Approach (CPA) meetings organised by the CMHT and we saw that reports of these meetings were included in their care records. Staff from the service also attended these meetings to give the CMHT information about people's current mental health and well-being and participate in reviews of people's medicines.

Arrangements for staff to consistently identify and act on people's needs required improvement. The service needed to enhance communication so that the CMHT always received full information to enable people to benefit from good quality decision making about their support. For example, on the morning of the inspection we spoke to a person who was very sleepy, they told us they had slept well. When we spoke to the manager and staff about it they told us this was a long standing issue. They said the person was often like this in the mornings and it was possibly due to their medicines which they were prescribed to address their mental health needs. Staff said because the person was usually drowsy in the mornings they did not go out to an activity which they enjoyed until the afternoon. We checked the notes of the person's last CPA meeting on their care record and staff from the service had not told the CMHT about this drowsiness when the person's medicines were discussed. We spoke to the manager about this and he told us the issue would be raised with the person's CMHT so that their medicines could be reviewed.

We spoke with a person who was sitting in the lobby. Staff told us the person spent most of their day there. We asked the person about their interests, which they told us about, although they said they were their "past interests before I became ill". When we checked the person's care records there was nothing at all written in relation to their interests. There was no evidence that staff had asked them about their interests. A member of staff told us the service was seeking to encourage the person to go back to a day centre which they previously attended but had not attended for several weeks. The person said they may go back to the day centre in the near future. It may have been possible for staff to support the person to identify and follow individual interests of their choice within the service or in the community. Arrangements to encourage people to identify and follow their interests could be improved.

Staff and the manager were knowledgeable about people's long-term mental health conditions. For example, they were able to explain how a person's individual mental health needs affected their behaviour. Records were kept of the discussions staff had with health professionals and the plans that were in place in relation to the assessment and treatment of people's mental health needs. For example, a person's care records included information about the steps that had been taken to ensure a person's mental health was urgently reassessed by a psychiatrist.

People had a monthly meeting with a key member of staff who had the responsibility for co-ordinating their support. A person told us these sessions, "were quite helpful". Reports of these meetings showed staff supported people to be involved in reviewing their health and making plans about how to become more independent. For example, a person's plan to promote their independence included sessions with a staff member to practice making their own hot snacks in their room. Another person's record stated, "We discussed how to get help to stop smoking but [person's name] does not want to stop." There was evidence support plans were regularly reviewed and updated and people were fully involved in this process.

The service had a complaints policy and people we spoke with said they had received written information about it. People said they would complain to their key worker if they wanted to raise a concern and said they thought it would be sorted out.

Requires Improvement

Is the service well-led?

Our findings

We saw a copy of the provider's service review audit dated 16 September 2014. This noted, "Few of the recommendations of the last review [which took place in October 2013] have been acted upon. There are still gaps in staff supervision files, there is no service user induction and staff files are not all kept up to date." The manager showed us a report which confirmed he is now following up on these issues as well as new recommendations from the September 2014 review.

We noted the service review included the auditing of four people's care records. This consisted of a check of the dates of completion of key documents such as key worker session reports and support plan reviews. However, there was no information on the quality of these records in relation to responding to people's needs and it was unclear whether medicines administration records had been checked. The report detailed the outcome of an interview with a person who had the role of representing all the people who used the service in meetings with the provider. The person had said they felt managers listened to their views. However, there was no evidence in the report of people's views on how they were treated by staff or their quality of life. In addition, the person interviewed had raised the issue of a holiday for people and asked for something to be done about this. The service review did not include an action point on this. The provider's systems to monitor and improve the quality of the service were not sufficiently thorough and robust and identified areas for improvement were not followed up in a timely way. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A person told us, "I think the service is run ok." At the time of the inspection the service did not have a registered manager. On the day of the inspection we met the manager of the service who had been in post for three weeks. The provider advised us they do not intend to seek a registered manager for the service as they have plans for major changes to the service from April 2015. A member of staff told us the new manager was positive and enthusiastic and had given them constructive criticism in order to assist them to develop their skills. They said the management team had been open with staff about the changes that were taking place in the service and how these would impact on staff and people.

Notes of one to one meetings between a member of staff and the current manager showed staff were able to raise and discuss team-working and people's support. The previous manager of the service had held regular meetings with people and issues such as the menu were discussed.

Adverse incidents were logged and reviewed appropriately. For example, records showed actions had been taken in relation to a recent incident and then discussed at a team meeting so staff understood what had happened and how to reduce future risks. The CQC had been notified appropriately of incidents which had occurred at the service.

A health professional told us that from their observation staff were always open and honest in their communication with people. They said people had been effectively supported with their mental health needs that they considered the service to be well-run.

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 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **People were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15 (1) (c).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People were not protected against the risks associated with the unsafe use and management of medicines. Regulation 13.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **People were not protected against the risks of inappropriate or unsafe care by effective systems to monitor the quality of the service. Regulation 10 (1).**