Creative Support Limited

Creative Support - Leonora Street

Inspection report

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Ratings

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

Overall summary

We inspected this service on 17 and 18 June 2015. The inspection was unannounced. At our previous inspection in October 2013, the service was meeting the regulations that we checked.

The service provided accommodation and nursing care for up to 16 people who have long term, complex mental health needs. Sixteen people were living at the home on the day of our inspection.

There was a registered manager in post at the time of our inspection. 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 registered manager was not at the home on the day of our inspection. On the second day of our inspection, we met with the service director who had been allocated to take responsibility for the home in the absence of the registered manager.

Summary of findings

The provider had not informed us of some important events that had occurred in the service. The provider did not always notify us of referrals made to the safeguarding authority or when incidents were reported to the police and failed to notify us of a deprivation of liberty safeguard approval.

The provider did not monitor and review staffing levels to ensure there were always enough staff to meet people's needs. There were no systems in place to ensure staff received effective induction, training and support to meet people's needs. Staff received supervision but this was not sufficient to meet the needs of nursing staff that required feedback and support regarding their clinical practice. Some staff felt the manager did not promote a positive, open culture at the home that encouraged all staff to raise concerns and question practice.

Staff understood the provisions of the Mental Capacity Act 2005 (MCA) but did not always recognise that people were being restricted. One person was under a Deprivation of Liberty Safeguard at the time of our inspection and one application was pending.

Most people did not have a personalised care plan to address their identified social needs and people were not supported to engage in activities and maintain links with the local community.

The provider's monitoring systems in relation to infection control, medicines and the environment were not always effective. The provider had not reviewed complaints and had failed to identify that the procedure was not effective in supporting people living at the home to share their experiences or raise concerns.

People who were able to tell us their views said they felt safe living at the home. Staff understood their responsibilities to keep people safe from harm. Risks to people's health and wellbeing were assessed and plans were in place that minimised the identified risks. The provider followed appropriate recruitment procedures to ensure staff were suitable to work in a caring environment.

People received their medicines as prescribed and had access to health professionals to support and maintain their health. People's relatives were made welcome when they visited and staff kept them informed of changes in people's care and support.

Staff were patient and responded to people in a caring manner. People's privacy and dignity was promoted and supported by staff. Staff gave people some choice and independence over day to day decisions but people were not always supported to be involved in decisions about their care and support.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back 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?
The service was not consistently safe.

The provider followed suitable recruitment procedures but staffing levels were not monitored and reviewed to ensure there were sufficient staff on duty to meet people's needs at all times Risks to people's health and wellbeing were assessed and plans were in place to minimise the risks and staff understood their responsibilities to keep people safe.

Requires improvement

Is the service effective?
The service was not consistently effective.

Staff did not receive effective induction, training and support to ensure they had the up to date skills and knowledge they needed to meet people's needs. Staff understood the requirements of the Mental Capacity Act 2005 but did not always recognise ways in which people were being restricted. People had a choice of meals and were supported to eat a balanced diet to minimise risks to their nutrition. People were supported to access other healthcare services when they needed them.

Requires improvement

Is the service caring?
The service was caring.

People were supported to make day to day decisions. Staff were patient, treated people with kindness and promoted people's privacy and dignity. People's relatives were able to visit as they wished and were kept informed about their relative's care and support.

Good

Is the service responsive?
The service was not consistently responsive.

People's identified social needs were not being met. The complaints procedure was not effective and did not support people to share their experiences or raise concerns and complaints. Care records were reviewed and kept up to date and staff shared information at handover to ensure people's changing needs were responded to.

Requires improvement

Is the service well-led?
The service was not well led.

The provider did not always inform us, as required, of important events which occurred in the home. The manager had not created an open culture at the home and some staff did not feel able raise their concerns or to question practice. The systems in place to assess and monitor the quality and safety of the service were not effective.

Requires improvement

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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.'

The inspection was undertaken on 17 and 18 June by one inspector and was unannounced.

Before the inspection we reviewed the information we held about the service. We looked at information of concern we had received and the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send us by law. We spoke with the service commissioners. It is the responsibility of commissioners to find appropriate care and support services for people, which are paid for by the local authority. We also spoke to the local authority safeguarding team to get information about ongoing investigations and report further concerns we had been advised of during our inspection process.

On this occasion, we had not asked the provider to send us a Provider Information Return (PIR). 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.

We spoke with seven people who lived at the home and one relative. We spoke with the Service Director, three nurses, one support worker, the cook and a member of the administration staff. We also spoke with two health care professionals. We spoke to two members of staff on the telephone. We observed care and support being delivered in communal areas and observed how people were supported to eat and drink at lunch time.

We looked at four people's care records to see how their care and support was planned and delivered. We reviewed four staff files to check people were recruited safely. We looked at the training records to see if staff had the skills to meet people's individual care needs. We reviewed checks the manager and provider undertook to monitor the quality and safety of the service.

Requires improvement

Is the service safe?

Our findings

People and staff told us that sometimes there weren't enough staff on duty. One person told us, "We don't get to do anything".Staff told us staff had left and not been replaced and most shifts needed to be covered by regular bank staff or agency staff. One member of staff told us, "There are not enough regular nursing staff, we are struggling to cover shifts". Another staff member told us, "We struggle to get people out and about. For most of the day we observed that people spent time in their rooms or went in and out of the garden to smoke. Staff were available in the communal areas and responded to people promptly when they asked for assistance. At lunchtime staff were on hand to support people who needed assistance with their meal and we observed that two people were supported to go out into the community. The provider told us staffing levels were calculated based on people's identified needs but staff told us and records showed that staffing numbers were not monitored and reviewed when people's needs changed. For example, staffing levels had not been reviewed to ensure there were sufficient to meet the needs of a person who required the support of two staff to minimise some identified risks. This meant that the provider could not be sure staffing levels remained flexible and sufficient to meet people's individual needs and keep them safe at all times.

Staff we spoke with understood their responsibilities to keep people safe and protect them from harm. Risks to people's health and wellbeing were minimised because risk assessments were undertaken on admission to the home and these were reviewed regularly. Alongside identified risks, triggers were identified and an agreed action plan was in place for staff to follow. Staff were able to tell us about people's needs and how they supported them and this was consistent with what we read in their care plans and what we observed. For example, one person was assessed to be at risk of self-neglect when they were in a low mood and we heard staff prompting them regarding their personal care and observed staff spending time with them on a one to one basis discussing their health needs. Personal evacuation plans were in place for each person but we saw that these had not been reviewed to ensure staff had up to date information to keep people safe in the event of an emergency such as fire.

People received their prescribed medicines safely. We observed a member of the nursing staff administering the lunchtime medicines and saw that people received their medicines as prescribed. We saw that medicines were stored securely in the home in line with legal requirements. For people who had their medicines prescribed on an 'as required' (PRN) basis, there was a protocol in their care plan to protect people from receiving too little, or too much medicine.

We reviewed four staff recruitment records which showed that references were followed up and checks were made through the Disclosure and Barring Service (DBS) to check staff's suitability to work in a caring environment. The DBS is a national agency that keeps records of criminal convictions. Staff told us they had attended an interview with the manager and confirmed that their references had been followed up and checks made with the DBS before they started work. This showed the provider followed recruitment procedures which minimised risks to people's safety.

Requires improvement

Is the service effective?

Our findings

We saw some people who lived in the home displayed behaviour that challenged their safety and that of others. Some staff told us they had not received training to support people with behaviour that challenged. They told us they were not confident in supporting some people who displayed behaviour that challenged and contacted other health professionals involved for support and advice. A health professional who visited the home told us staff were having to manage aspects of behaviour that were new to them. They told us, "They are managing as best they can". This meant the staff were not always trained to meet people's individual needs.

There was no consistent process in place to support new staff. We could not find any information that new staff received an induction to enable them to meet the individual needs of the people using the service. Some staff told us they had discussed training with the manager when they started at the service, but this had not happened.

There was no system in place to ensure that staff's knowledge and skills were kept up to date to enable them to provide effective care for people living at the home. The nursing staff told us they did not receive clinical supervision. Clinical supervision supports staff to discuss and improve practice and increase understanding of professional issues, including best practice in supporting people with challenging behaviour. One member of nursing staff said, "The lack of clinical supervision means that we don't have the opportunity to share and discuss decisions about people's care, rather than making them in isolation". This meant people were not supported by staff who received the necessary supervision for them to carry out their role and responsibilities effectively.

The provider was not consistently meeting the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The legislation protects people who are not able to consent to their care and treatment and ensures people are not unlawfully restricted of their freedom or liberty. Records showed that one person was on a DoLS and another application was awaiting assessment by the local authority.

Staff understood the provisions of the MCA and DoLS and recognised how a person might be deprived of their liberty by being prevented from leaving the home unescorted. However, staff had not considered other ways people were being restricted. For example, we saw that a person had been assessed as not having capacity and heard them constantly asking for a cigarette. Staff told us this person would smoke all their cigarettes at once if they were not restricted but there the assessment did not show how this was managed. No application had been made to explore if the restriction was in their best interest.

People told us they liked the food and a menu had been developed in consultation with them. Staff told us and records showed that people regularly made comments about the food and requested meals for special occasions. People told us they had a choice of meals and drinks daily and made their selections in the morning. At lunchtime, we saw that most people were able to eat independently, but staff were on hand to provide support where needed. This meant people were supported to eat and drink enough to maintain good health.

Records confirmed that people's nutritional needs were assessed. If required a specialist diet was provided, for example for people with allergies and swallowing problems. We saw that a person had been assessed to be at risk of choking which made it difficult for them to eat. A member of staff explained how the person was at risk and we observed them being supported with their meal at lunchtime to keep them safe. We saw people's weight was monitored as needed and people were referred to the GP when their weight changed significantly to maintain their health needs effectively.

People told us they were supported to maintain good health and had their day to day health needs met. One person told us, "I think I'm due an optician's appointment, they [the staff] remind me and I've been asked if I want to go to the dentist". We saw that staff sought advice when people's skin integrity was at risk and the advice was followed which showed that staff took appropriate action to ensure people's health needs were met effectively.

Good

Is the service caring?

Our findings

We saw staff treated people with kindness and responded to their needs quickly. People had mixed views about the staff. One person told us, “It’s the best home I’ve ever been in, staff are more caring”. Another person told us they liked some staff more than others. A third person said that sometimes staff were too busy to come out of the office and mix with them. We saw people going into the office to talk to staff who listened and responded to them in a caring manner.

People we spoke with told us they could make day to day decisions and choose how they spent their time. One person told us, “I get up at 7am and can stay out until 10pm if I want to. I choose what I want to do every day, this morning I’ve been out for my breakfast, I had a cheese and bacon bap”. Another person told us, “I like to spend time in my room. It’s beautiful, I like to keep it clean”. This demonstrated people were supported to make choices in their day to day lives.

We saw people were offered support from advocacy services to help them make decisions. An advocate is an independent person who is appointed to support a person to make and communicate their decisions. For example, some people were supported to make decisions to have someone manage their finances or to manage some of their medicines themselves. This showed people were supported to be actively involved in making decisions about their care and support.

We observed people’s privacy and dignity was promoted because staff knocked on people’s bedroom doors and sought permission before entering. We saw that staff respected people's privacy by administering their medicines individually in the treatment room.

A relative we spoke with told us they were always made welcome when they visited. They said, “Staff know our names and always make us a drink when we’re here”. They told us the staff kept them informed about their relative’s care and made them aware of any changes. We observed a staff handover and heard staff discuss how people were and shared information about changes which may impact on people. For example, one person received regular visits from a relative who had become ill and staff were concerned how this might affect them. This showed that staff supported people to maintain contact with people who mattered to them.

Requires improvement

Is the service responsive?

Our findings

People told us they were bored because there weren't enough organised activities and if activities were arranged, they were often cancelled because there weren't enough staff to support them. For example, a regular walking group had been cancelled. We saw that most people did not have a personalised care plan to address their identified social needs and there were few planned activities for people to engage in. Staff told us that activities tended to be ad hoc because people often lacked the motivation to be involved on a sustained basis. We found there was a culture among some staff of finding reasons not to arrange activities or support people to go out into the community. For example, one member of staff told us, "Staff are saying we are short staffed, but I can't see what they are complaining about, they don't seem to do anything with people". Another member of staff told us, "When planning activities for residents, some staff members make comments and ignore you. They reel off every negative thing possible about an activity you are trying to arrange and do not provide any help or support". This meant some people were not supported to receive personalised care that was responsive to their individual needs.

There was a complaints procedure in place but this was not always responsive in supporting individuals to share their experiences or raise a concern about the service. A relative we spoke with told us, "I haven't received any information or seen anything at the home". They told us they felt they could raise any concerns and they would be listened to. Discussions showed that people who used the service may require further support to make a complaint as one person asked us how they could raise a concern they had. We requested information about complaints received by the provider but this did not show how the provider had used the information to improve the service. There was no information on how people with complex needs were supported to raise their concerns. The provider could not be sure that the complaints procedure was accessible to everyone using the service to ensure any concerns or complaints are investigated thoroughly and any necessary improvements made.

Care records we looked at were regularly reviewed and contained a variety of information about each individual person, including a colour coded list that detailed things that were important to the person, for example having their glasses and looking smart, and more important items, such as how staff should identify the person's need for pain relief. We observed staff updating daily records and sharing the information at handover to ensure all staff had up to date information about people's care needs.

Requires improvement

Is the service well-led?

Our findings

We found the provider had not informed us of some important events that had occurred in the home. The provider's safeguarding log showed that the provider did not always notify us of referrals made to the safeguarding authority or when incidents were reported to the police. We also found that the provider had failed to notify us of a deprivation of liberty safeguard approval. This meant the provider was not meeting the requirements of their registration with us by keeping us informed of risks to people.

This was a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009 (Part 4).

We received information before and after the inspection about the lack of leadership at the home which raised safeguarding concerns about some people. Some staff told us the manager was approachable but other staff told us there was a cliquey atmosphere and felt they were not always treated fairly. Staff knew how to whistle blow but some said they were unsure if they would be supported. A whistle blower is a person who reports concerns about wrongdoing in the place where they work. Some staff told us they had raised concerns in the past but these had not been acted on. For example, a member of staff told us they had spoken to the manager about the conduct of other staff members but they had not taken any action. We discussed these concerns with the safeguarding authority as part of their ongoing investigations at the home.

We looked at the systems in place to monitor quality and safety. We found that the bathrooms were not clean and required some maintenance. For example, one of the toilet seats had been broken for some time and staff told us the manager had not arranged for it to be replaced. Regular maintenance checks had not been carried out on equipment such as the hoist and some essential checks, for example on the hot water system, were also due.

We found errors with the recording of medicines stocks. Staff had received training in the administration and management of medicines but the manager had not carried out any checks or audits to ensure medicine records were correct.

Staff told us and records confirmed that accidents and incidents were recorded. However, there was no evidence to demonstrate that the provider shared information on patterns and trends with the manager so that action could be taken to prevent incidents in the future.

We saw the provider did not have systems in place to gather people's opinions on the quality of the service. However, meetings were held at the home for people to give their views on the day to day routine at the home but there was no evidence that relatives, professionals or staff had been asked for their feedback on the care provided. One person told us, "They haven't asked me what I think and as far as I know, they haven't asked my relatives". A relative we spoke with had not been asked to give their views.

These were breaches of 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
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective systems in place to assess, monitor and improve the quality and safety of the services people received. Regulation 17(2)(a). The provider did not create an environment in which staff felt able to raise concerns about the health, safety and welfare of service users. Regulation 17 (2)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider did not always notify us of any allegations of abuse in relation to a service user, or any incident which is reported to or investigated by the police. Regulation 18(2)(e)(f). The provider did not notify the Commission of the outcome of a request to a supervisory body for a standard Deprivation of Liberty Safeguard authorisation, pursuant to Part 4 of Schedule1 of the Mental Capacity Act 2005. Regulation 18(4A-B)(c-d)