Careline Lifestyles (UK) Ltd

Deneside Court

Inspection report

St Josephs Way
Jarrow
Tyne and Wear
NE32 4PJ

Tel: 01915191574
Website: www.carelinelifestyles.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 17 November 2015. We undertook this unannounced focused inspection on 21 March 2016 to check the safety of people who used the service as CQC had received a number of statutory notifications, since the last inspection, where police had been involved in incidents that had taken place with people who used the service. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales.

Deneside Court is a care home providing accommodation with nursing and personal care for up to 40 people with learning disabilities, physical and neurological disabilities. The home is divided into five units which comprises 25 individual bedrooms with en-suite facilities over three units and two units consisting of 15 self-contained flats with kitchen facilities. A registered manager was in post at the time of the 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.

We found the provider had identified in most cases where improvements were required to keep people safe. However some arrangements had been not put in place in a timely way to keep people safe.

Staff had not received all the training they needed to do their job effectively and to ensure the safety of people who used the service.

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

This report only covers our findings in relation to those legal requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Deneside Court on our website at www.cqc.org.uk.

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

Not all aspects of the service were safe.

Some systems had been introduced to improve aspects of safety within the service when supporting people with diverse needs. However, they had not been consistently maintained to improve the safe running of the service.

Staffing levels had increased to ensure people's safety. Accidents and incidents had reduced as a result of changes to the environment. Records provided guidance for staff about how to deliver people's care and to work with people if they were distressed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not all received training to provide safe and consistent care to people with distressed behaviour. They had not received specialist training about some peoples' needs to enable them to provide care and support that was safe and effective.

Deneside Court

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Deneside Court on 21 March 2016. This inspection was carried out to check that arrangements were in place to keep people safe. We inspected the service against two of the five questions we ask about services: 'Is the service safe?, and, Is the service effective.'

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

This inspection was undertaken by two adult social care inspectors. It was carried out as we had received information of concern. Due to the concerns we wrote to the provider to request specific information to check how people were being cared for safely. After assessing the information it was decided to carry out an unannounced inspection.

During the inspection we spoke with nine people who used the service, two nurses, eight support workers, the registered manager, the head of home operations and the head of strategic development and commissioning. We reviewed a sample of care records. These included four people's care plans, the staff training records and accidents and incidents log. We discussed our findings with the registered manager.

Requires Improvement

Is the service safe?

Our findings

The inspection was carried out as we had concerns due to the range of people's diverse needs and the number of incidents that had been reported to the Care Quality Commission (CQC) that arrangements were not in place to ensure people were kept safe at all times. People were positive about the service and the staff who supported them. Comments included, "They're all friendly here, nothing needs improving," "I feel safe," "I love [name of staff member]." "Happy," "It's alright here," "There's enough going on," and, "Staff are nice here."

The registered manager told us staffing levels were determined by Head Office. Our findings did not support that people's dependency levels had been taken into account to ensure the appropriate numbers of staff over the twenty four hour period. At the time of our inspection there were 37 people living at the home. We were told and staffing rosters showed there were two nurses and 20 support workers on duty to provide care to people from 8am to 8pm and nine support workers and two nurses from 8pm to 8am. This included providing one to one support to some people in the service. The care staff team were supported by the therapeutic services team which consisted of a senior occupational therapist and junior occupational therapists, behaviour care lead and therapy assistants. The number of incidents reported and peoples' comments maintained that staffing levels were not always sufficient each day to provide safe care to people on the Lincoln Unit. This unit accommodated eight people with learning disabilities, mental health needs and some distressed behaviours who were supported in their own apartments. However, we were told after the inspection of the arrangements that had been put in place and were now operational to ensure people were kept safe over the twenty four hour period.

Some of the arrangements to keep people safe had already been introduced and were working well at a similar service operated by the provider. Two new positions had recently been created by the provider to work across all their services. The head of home operations was a newly created tier of management to support all the registered managers of services. The head of strategic development and commissioning liaised with commissioners of placing authorities who funded people's placements.

A needs analysis had been carried out by the newly appointed head of home operations and a number of arrangements had been introduced to ensure people's safety and well-being. It had been identified staffing levels reduced at 8pm when there was a change to night staffing levels, however people were still needing staff support at this time as they did not go to bed until later. Arrangements were now in place for five staff including senior support staff to work 10am until 10pm across the home on a rotational basis to support the 8pm -8am shift. This meant extra staff were available each day until 10pm to support the night staff. Increased staffing levels also gave staff the flexibility to engage and carry out activities with people in the evening. Rosters showed day time staffing levels were five support workers, including a senior support worker, for each unit which accommodated up to a maximum of 10 people.

The head of strategy told us, "We have reviewed our admission procedure and have a step by step approach…We are also looking for more background information about people. It's about trying to get everyone involved that should be, we want to make sure that we are getting the right person in." The head of

home operations informed us after the inspection arrangements were in place for the registered manager, supported by the director of care, or a nurse assessor to carry out future pre-admission assessments to ensure the compatibility of placements of people to the service and to check that staff had the required skills to meet people's needs before they were admitted. This had previously been carried out for some services by the admission's team based at head office who would not necessarily know the skill mix and if people who were to be placed at the service may be compatible with existing people. The head of home operations gave an example of this local knowledge being used for a placement to ensure a prospective person's safety. An emergency admission had been requested for a person with a tracheostomy, (an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help a person breathe) but there had been concerns that the person may not have been kept safe at all times due to other peoples' needs. The placement had been postponed until the necessary checks were carried out to ensure the person would be kept safe and that staff were appropriately deployed.

The registered manager was aware of potential safeguarding incidents that should be reported. A log book was in place to record minor safeguarding issues which could be dealt with by the provider. We found concerns had been raised appropriately since the last inspection concerning the care and welfare of people. All alerts had been referred to the local authority safeguarding adult's team and had been investigated and resolved.

Staff were aware of the reporting process for any accidents or incidents that occurred. CQC had received several statutory notifications where the police had become involved. Some were due to people's distressed behaviour when staff had not been able to de-escalate the situation and either staff or people who used the service were therefore thought to be at risk. We were told the therapy assistant looked daily at any incidents that had been reported and they looked at any trends. They then informed the registered manager. Records showed the forms covered the numbers of accidents, safeguarding referrals and notifiable incidents. We saw the action that was taken as a result of the analyses to ensure people were kept safe. For example, some of the police incidents that had been reported had taken place between people with distressed behaviour accommodated in two units with communal areas, side by side. Incidents had taken place as some people had been agitated, anxious and distressed. We saw the environment had improved as doors had been put in place on the corridor to separate the two units. This had helped reduce noise levels and create a more tranquil environment for people. Analyses showed the number of incidents had reduced from 23 that had been reported between January and the beginning of March 2016 to five since March and end of April 2016. We were also told three of the people who had been involved in some of the incidents were no longer living at the service and had moved elsewhere.

The head of strategic development and commissioning told us they liaised with the police and a link person had been identified and established to enable communication and provide support to the service if any incidents needed to be reported. Police were invited to be involved in any de-briefing sessions after an incident. This was to ensure there was a consistent approach employed by staff when contacting the police if an incident needed to be reported. The head of strategic development also told us there was a lack of multi-disciplinary planning and support for new admissions. They were communicating with all the commissioners of people who used the service to ask for reviews of people's care to be carried out by all the placing authorities. This was to check people were receiving the correct levels of care and support and that they were appropriately placed. We were told the service had previously accepted some people as emergency admissions when alternative accommodation had not been available that may have been more appropriate for some people.

Care plans were in place to show people's care and support requirements when they became distressed and they were regularly updated to ensure they provided accurate information. A new care planning system for

distressed behaviour was being introduced called positive behaviour care planning which would give staff more insight and understanding as to why people may become distressed and challenging. This was to supplement the behaviour management guidelines that were in place for people to help staff support them. A three page profile was being completed for each person so staff would have succinct information to help them recognise triggers and help de-escalate situations if people became distressed and challenging. The head of home operations told us they were due for completion by May 2016. Behaviour care lead and therapy assistants, employed by the service, were also working extra hours to ensure arrangements were in place for staff to support people with distressed behaviour safely

We were satisfied with some of the arrangements that had been put in place to keep people safe but we considered the improvements needed to be consistently maintained and should have been implemented in a more timely way.

Requires Improvement

Is the service effective?

Our findings

We had concerns people that although some arrangements had been made to ensure people received safe care and treatment all the necessary safeguards were not in place. Staff had not all received training to manage distressed behaviour and specialist training to understand some people's care and support needs before people started to use the service. This was to ensure people received safe care and treatment.

Some staff told us and training records showed they had received management of potential and actual aggression (Mapa) training before they started working with people in order to protect people they worked with and themselves if an incident of aggression was likely to take place. Staff were also receiving positive behaviour support training to help them understand and to give them more insight into why people may become distressed and agitated. At the time of inspection 25 people had received this training, 29 people had received it by April 2016. However, this had not been carried out in a timely way as there were 83 people on the staff team and less than half of staff had received the training. This was despite previous assurances from the provider that all staff would receive this training as soon as possible to ensure people were supported safely. After the inspection we were informed all staff would have received the training by the end of June 2016.

Staff had not all received training about any specialist care and support needs people may have. For example, for specialist mental health needs such as self-harm. A staff member had commented, "We have lots of training, but not for the issues we have here – there is not enough. I haven't done training in self-harm; we need more training on the different mental health conditions… People should have an awareness, you need to have staff that are aware of things – how can we help people if we don't understand." The head of home operations told us this was being addressed. A monthly training needs analysis had been introduced and was to be carried out by the registered manager to identify any specialist and clinical needs of current and prospective people to the service. This was to ensure staff were trained before people started to use the service or they were to receive training if people's needs changed so they had some insight into a particular condition. We were told the clinical coordinator held two training sessions a week to provide any identified specialist training and skills training to staff to help them understand peoples' care and support needs and to keep people safe.

This was a breach of Regulation 12 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 18 HSCA RA Regulations 2014 Staffing The registered person had not ensured staff were trained to provide safe and effective care to people at all times. Regulation 18 (2)(a)