Sunderland Home Care Associates (20-20) Limited

Cherry Tree Gardens

Inspection report

Orchard Place
Houghton Le Spring
Tyne and Wear
DH5 8JY

Date of inspection visit:
30 August 2017
04 September 2017
13 September 2017

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05 December 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 30 August and 4 and 13 September 2017.

Cherry Tree Gardens provides a personal care and support service to people living in their own flats and bungalows within purpose built accommodation run by an external housing provider. There are 40 apartments and seven bungalows on site. The service is known as an "Extra Care" service and provides on-site support seven days per week and 24 hours per day including the use of a community alarm.

At the last inspection in 2016 we found the provider had breached Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider did not have accurate records to support and evidence the safe administration of medicines. The provider did not have effective quality assurance processes to monitor the quality and safety of the service provided, and to ensure that people received appropriate care and support. We asked the provider to take action to make improvements. The provider agreed they would be compliant with the regulations by 31 December 2017. During this inspection we found some improvements had been made. However we found further breaches of Regulations 12 and 17.

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.

Pre-employment checks were carried out by the provider before staff started working in the service. Staff who were new to the service completed an induction, and were then supported through training, supervision and appraisals.

The service met the requirements of the Mental Capacity Act. Staff had been trained in the legislative requirements. We found consent had been obtained from people to enter their accommodation in the case of an emergency. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

We found some of the people who used the service had complex health needs. Care plans were not in place to ensure people with complex needs received appropriate care. Staff were not always able to tell us about people's conditions.

Staff had conducted an assessment of people's needs. However we found where people had specific needs care plans had not been put in place to guide staff on how to meet those needs. This meant people were put at risk of receiving inappropriate care.

Records in the service were found to require updating to ensure they were accurate and all relevant

information about people's care needs was available to staff.

Staff had recorded accidents in the service. We found these had been monitored by the manager to prevent reoccurrences.

People we spoke with during the inspection gave us mixed views about the standards of care they received. Whilst some people were complimentary about the care they received from staff, others said the standards of care could be improved.

The provider had introduced quality audits to the service. We saw the audits were being carried out and resulted in actions plans with deadlines to make improvements.

Partnership working arrangements were in place between the housing provider and the service.

The provider had in place a complaints policy. We found complaints irrespective of their seriousness were documented in different ways according to how they were received. We have made a recommendation about this.

During our inspection we found two of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

We could not be reassured that people had received their medicines as prescribed. We found insufficient actions had been taken to reduce the risks to people who did not take their medicines.

The service had failed to address people's personal risks and provide guidance to staff on how to mitigate those risks.

Staff recruited to the service had undergone pre-employment checks to ensure they were suitable to carry out their roles.

Is the service effective?

Requires Improvement

The service was not always effective.

We found staff who supported people to eat and drink did not always record people's intake to demonstrate people were receiving sufficient nutrition.

Staff had received support through induction, training, supervision and appraisal.

Daily handover records were in place to ensure staff were kept up to date with people's changing needs.

Is the service caring?

Requires Improvement

The service not always caring.

We received mixed views from people about the standards of care they had received. Whilst some of the people we spoke with described the care in positive terms, other people felt care was lacking.

Relatives we spoke with who wanted to speak to the managers in the service as natural advocates for people who used the service, found staff to be defensive.

Confidential records were stored appropriately in the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff had completed an "Individual Person Centred Care Plan" for each person who used the service. This plan included assessment questions about people's needs and personal preferences.

We found where specific needs had been identified associated care plans were not in place to guide staff on how to provide people's care.

We recommend the provider reviews their complaints procedure to ensure all complaints are documented in an accessible format.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Records held by the service needed to be addressed to ensure they were accurate, complete and were a contemporaneous record of the care people needed and received.

A survey to gather people's views about the service was carried out in March 2017. For the most part people gave positive responses.

Audits to monitor the quality of the service were in place. These had resulted in action plans with deadlines to improve the service being put in place.

Cherry Tree Gardens

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 comprehensive inspection took place on 30 August and 4 and 13 September 2017. The inspection was unannounced.

The inspection team consisted of two adult social care inspectors, a specialist advisor in nursing care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before we visited the service we checked the information we held about this location and the service provider. For example we looked at the inspection history, safeguarding notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law.

Before the inspection, the provider completed 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.

During the inspection we spoke with eight staff including the registered manager, the on-site manager, their deputy, training manager, two staff carrying out quality audits and two care staff. We spoke with nine people who used the service and reviewed six people's care records. We also spoke with five relatives. We reviewed documentation held by the provider in respect of the regulated activity.

During the inspection we also spoke with the housing provider's on-site representative to look at the working relationships between the housing provider and the service. The housing provider commissioned the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found staff were not always administering people's medicines in a safe manner. This was a breach of Regulation 12. At this inspection we saw that some improvements had been made but that further improvements were needed to ensure people who used the service received safe care and treatment.

We looked at risk assessments in the service. The provider had service risk assessments in place to guide staff as to potential hazards and what actions to take to avoid incidents. These included managing behaviour that challenges, violence and lone working.

We reviewed the care needs of one person who was at risk of choking and found the choking risk had not been addressed. We spoke with staff about a person who had complex health needs. Staff were not aware of the person's medical conditions and what actions they were required to take in case of an emergency. Staff were required to support this person to access the toilet and to assist with washing. The person had a specific skin condition. We spoke to two members of staff who were unable to tell us about this condition. One member of staff told us they had not seen a description of the condition in the person's notes. We found there was no evidence in the person's care plans to guide staff regarding how to observe for signs of a change in the person's health given their conditions and the action to take in the event of changes. We found people were at risk of receiving inappropriate care as staff were not always aware of how to mitigate risks and this was compounded by a lack of information in people's care records.

Staff supported people with their medicines. We checked to see if this was carried out in a safe manner. One person said, "I don't have a problem receiving my medication on time." We found arrangements were in place whereby people self-administered their medicines at different points of the day and staff provided support at other times. In one person's care records we saw staff had recorded that the person was not witnessed taking their medicines. One of the members of staff interviewed stated that this person often had their medicine cartridges intact with their medicine still present which indicated the person had not taken them. Staff were not given support and guidance about how to care for this person under these circumstances. We found the arrangements between the service and the person around their medicines was insufficiently robust to mitigate the risks of the person not taking their medicines. This meant this person was at risk of receiving inappropriate care.

We reviewed the Medication Administration Records (MARs) to check whether medicines administered to people were recorded accurately. On one person's MAR we saw 14 occasions when the code F was used (which indicates other reason for non-administration). There was no record as to the reasons why the medicine was not given. We spoke to a manager in the service about the MAR charts. They told us one of the reasons medicines might not be administered was if the person was out. They had just devised a new sheet so that reasons for non-administration could be documented. We found gaps in other people's MAR charts where staff were expected to administer people's medicine. Relatives told us they checked people's MAR charts and had also found gaps in the records. We could not be reassured people were receiving their medicines as prescribed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we spoke with people about feeling safe when using the service. One person told us, "I leave my home door unlocked because I trust staff with entering and leaving my home without any worry." They went on the say, "Staff talk to me and let me know they are around to keep me safe and secure". Another person said, "I like it here, the staff and carers make me feel safe and checking me regular." We found the service had two staff on at night time and one person commented on their presence. They told us, "I'm confident that the carers keep me safe from any harm when I'm in bed at nights."

Staff were trained on how to safeguard people. They understood if they had any concerns they needed to raise them with their manager. At the time of our inspection managers in the service told us there were no on-going concerns raised by staff.

We looked at the staff rotas for the service and found there was a regular pattern of staff on duty to meet people's needs. We heard staff work together and make arrangements to support people who needed care. We found people who used the service and their relatives held mixed views about staffing levels. One of the people we spoke with reported that it can take up to 30 minutes for staff to respond to an emergency alarm. Some people told us the service was sometimes short staffed and that staff had to come to work from another service. Another person said, "The carers are very efficient here – they can respond to your call in minutes if anything is wrong both day and night". They added, "Staff and carers are very patient with you and they spent extra time with me when I need it." This demonstrated people had mixed views about having enough staff on duty.

Staff who were recruited to work in the service had undergone a number of checks before they commenced employment. Disclosure and Barring Service (DBS) checks were carried out and two references were obtained for successful applicants. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults. DBS checks were carried out annually. Proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates. We also saw copies of application forms which detailed the past employment, skills and experience of staff members. This meant the provider had an effective recruitment and selection procedure in place and carried out relevant vetting checks when they employed staff.

The service had accident records which showed when people who used the service or staff had an accident. We found one person had a number of falls recorded in their daily notes, but no accident record had been made. We asked staff why this was the case. They told us they were called to support people following their falls or accidents but these had not taken place during the time care was being delivered. Accidents were reviewed by the manager to see if actions could be taken to prevent repeat incidents.

Requires Improvement

Is the service effective?

Our findings

We saw staff supported people to eat. Some people had their meals prepared in the Bistro on the ground floor. The meals were delivered to people's rooms and staff provided the support for people to eat.

We looked at one person's daily notes and found staff supported them to eat and drink. However whilst staff recorded the person's fluid intake levels, there was no recorded guidance to staff on what their daily fluid intake should be and actions to take if their fluid intake levels were reduced. This meant documentation failed to give staff sufficient information. Guidance to staff on their need for thickened fluids had been provided by their relative. Staff had used the guidance in order to meet the person's care needs. In order to ensure their food intake was sufficient a relative had requested they were offered a desert. Records did not show they were consistently offered deserts. We could not be assured the records were accurate, complete and were a contemporaneous record.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. We found the provider documented in each person's individual care and support plan if there was anyone with 'Lasting Power of Attorney (LPA).' Someone with LPA for a person is able to make financial decisions or health care decisions on their behalf.

Consent had been obtained from people who used the service for staff to use keys to access their flats and bungalows in the event of an emergency. People who used the service confirmed staff sought their consent before supporting them. One person said, "Staff always speak to me before they do anything – for example - turn off the TV."

Once appointed to the service staff were provided with an induction. We saw signed staff induction records on file. One person told us, "The carers often have to train new people when they still need trained themselves in my opinion they are only training new carers to perform the same inadequacy job as themselves." We saw staff were visiting one person each day to support them to self-administer insulin for diabetes. Staff had not been trained in the safe management of diabetes care. The registered manager told the staff to arrange for diabetes training to be made available. On the last day of our inspection staff told us support for the person was now provided by the district nurse within the community but that the diabetes training would still go ahead.

We looked at staff training and found staff received training which was described as mandatory by the provider. This included moving and handling, first aid and medicines administration. Certificates were on file to confirm the training had taken place.

Staff also received regular supervision and appraisal. A supervision meeting takes place between a member of staff and their line manager to discuss their progress, any concerns they may have and training needs.

The provider had a daily handover in place which was supported by daily handover notes. Staff were given pertinent information about changes to people's care needs in the daily handover notes. This meant the provider had in place a communication system to ensure staff were up to date.

Requires Improvement

Is the service caring?

Our findings

We asked people if they found the service caring. One person said, "Carers have asked me in the past about the things that interest me and shown a genuine interest for finding out more." They added, "They always ask if there's anything more I can do for you before they leave which I think is nice". Some of the people we spoke with told us that the staff were reasonably caring and showed empathy when required, but some people felt there was not enough care demonstrated to satisfy their needs. One person said they felt some carers were, "Just here for the money." They said, "I have a major concern over carers talking on their personal mobile phone to their friends while on duty. "Two people we spoke with were very positive about the care they received but told us there were some carers who were not so caring. One person said, "I've noticed carers glancing at their watch suggesting they just want to get away as soon as possible." We found whilst some people reported that staff ensured their well-being, other people had a more negative view of the service they had received.

People had their own personal records in their homes and these were stored according to their own preferences. Records held by the service were stored in locked cabinets to protect people's confidentiality.

We found staff promoted people's independence in their own homes. This involved suggesting to people that they rang their own GP for assistance or contacting the mental health crisis team.

Two people we spoke with were very positive about the care they received but told us there were some carers who were not so caring. One person said they felt some carers were, "Just here for the money." They said, "I have a major concern over carers talking on their personal mobile phone to their friends while on duty." One person said, "I've noticed carers glancing at their watch suggesting they just want to get away as soon as possible."

Staff knocked on people's doors and asked permission to enter the person's home. One person said, "Carers respect me and always treat any sensitive information as confidential from other people living in the home unless I wanted other people to know". Another person raised concerns and said, "The carers constantly need prompting by me all the time to do their full duties."

We observed a member of staff interacting with a person and found they were polite and courteous. All of the thirteen people who responded to the provider's survey in March 2017 felt staff respected their privacy, behaved in a courteous manner and carried out personal care tasks in an appropriate way. However, none of the 13 people who responded to the survey were informed if their allocated staff member was going to be late.

During the inspection we were not able to observe care being directly given to people in their own homes. We asked people about the care they received. One person said, "I get very nervous at times and the carers are aware of this and keep me protected here."

A member of the inspection team spoke with a person in the presence of a staff member. The person

complained of pain and was upset. The staff member left the person's home. The inspection team member was concerned about the person and we alerted a manager about our concerns. The manager was not aware of the concerns and visited the person. The manager told the inspection team they had given the person some pain killers. We found that by the carer leaving this person without responding to their concerns, they had failed to show a caring approach to the care delivery of that individual.

Some people who used the service were able to self-advocate and convey to staff their needs. No one, at the time of our inspection who used the service had an advocate appointed from an external agency. An advocate is someone who helps a person express their views to others. We spoke with relatives who told us they had spoken to staff and the service managers to help improve the service for their family members and had found the managers of the service to be supportive of the staff actions.

Each person in their individual care plans had been asked the question about their end of life plans. Staff had documented each person's wishes or written down where people had no current plans. This showed the service considered people's needs and wishes at the time of their death.

Requires Improvement

Is the service responsive?

Our findings

We spoke with four relatives who told us they felt concerned that without their input and oversight the service would not have delivered the responsive care needed by their family members. One relative told us they felt the care provided and care records, needed to be improved. One person who had recently moved into the service had told their relatives that staff had not been administering their medicines. The relative told us the person had health conditions which meant they were unable to self-administer their medicines. A subsequent conversation between the relative and the staff member revealed this to be true. Relatives told us they had seen improvements to people's care after they had raised issues.

We found health and wellbeing issues identified did not directly correlate with more detailed plans and risk assessments to give staff guidance on how they were to provide person centred care to individual people. For example, we saw in an assessment document one person had a catheter. Staff were expected to provide support to the person with their catheter. However there was no care plan in place for the person's care. In another person's file we found they had diabetes and there were no documents in place to guide staff on what actions to take if they found this person unwell. Following a recent fall one person required the assistance of two staff; their assessment had been updated to reflect the need for two staff but not how the two staff were to support the person. We explained our findings to the registered manager who advised staff on how to amend the records.

We saw in one person's records staff had noted they were in a low mood, distressed and had expressed a wish to self-harm. We saw in their care plan staff had written the person had mental health issues and we asked staff to tell us about them. Staff told us the person had no diagnosed mental health condition and they believed the person to be feeling isolated. There were no care plans in place which addressed the person's mental well-being. We found the provider had failed to ensure staff were given guidance to manage any future potential risk of self-harm.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Each person who used the service had a document in their files entitled, "Individual Person Centred Care Plan". We found this document was a list of questions about a person's health and well-being. The document included contact details for people's relatives and questions to assess people's needs. For example the questions in the care plan included, "Do you have any fears or apprehensions?" and "Do you have a tendency to wander?" Personal choice questions were also asked about the time people preferred to get up and retire at night. This meant the provider had in place an assessment process to gather information about people's needs and preferences. Reviews of people's care plans were carried out on a regular basis.

The provider had in a place a complaints procedure. Relatives we spoke with told us when they had tried to make a complaint they found the managers who worked on site to be defensive. They told us when they had spoken to the registered manager they had received a better response. We saw the registered manager had sent a letter to the relative thanking them for their complaint and stating the actions they had taken.

We saw the complaints procedure differentiated between verbal and written complaints. Verbal complaints were to be recorded in each person's personal records. Written complaints were to be recorded in the office file. This meant irrespective of the seriousness of the complaint the way in which the complaint was received by the provider determined how it should be recorded. We found complaints made to the provider were only accessible by reading the records of everyone who used the service Two relatives told us they had made a complaint about money going missing from their family member's flats. One relative told us actions had been put in place to prevent a re-occurrence. No complaints had been recorded in the office. One staff member showed us a complaint they were currently addressing.

We recommend the provider reviews their complaints procedure to ensure all complaints are documented in an accessible format.

Requires Improvement

Is the service well-led?

Our findings

During our last inspection we found the provider did not have in place auditing systems to monitor the quality and effectiveness of the service. This was a breach of Regulation 17. At this inspection we found improvements had been made, although further improvements were required to achieve compliance with the regulation.

There was a registered manager in post. The registered manager was also a registered manager for other services run by the same provider. The registered manager held line management responsibility for an on-site manager and deputy manager at Cherry Tree Gardens.

Staff personnel files had been audited and an action plan was put in place to make improvements. The actions were delegated to supervisory staff who were given timescales to ensure improvements were made.
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Audits had been recently introduced to monitor the quality of care plans and daily records. Each of the audits resulted in a "Service User File Action Plan". Deadlines to improve the files had been set and the actions had been passed to the on-site manager for completion. We found the audits were not fully embedded in the service. Audits that had been completed failed to identify the areas requiring improvement that were found during this inspection. This meant that the provider had failed to develop and implement effective systems and processes to monitor the quality of the service that they were providing.

During the inspection we found records were not up-to-date or accurate. For example we found one person was described as being at low risk of falls. However we saw in their daily records they had had seven falls and no guidance was given to staff on how to support the person. We found risk assessments which needed updating. We discussed these with the registered manager who gave instruction to staff to update the records.

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

Staff explained to us that people had different expectations of an extra care service provided in a supported housing complex. Some people and their relatives expected them to be available for support 24 hours per day as if people were living in a care home. This had led to an incident where a person had called the service to pick up their TV remote off the floor. At the same time staff responded to calls from people using their emergency pendants. Other people believed they were similar to a domiciliary care service in the community and arrived at each person's home to carry out care tasks at pre-arranged times of the day. One person told us staff had refused to get them a bottle of milk, a relative told us carers had refused to heat up burgers in a microwave whilst other people spoke of night care workers popping in to see people and carrying out extra visits. We found staff were carrying out duties allocated to them by other professionals which were not a part of their commissioned role. During the inspection the registered provider addressed these issues.

Arrangements for partnership working were in place with the housing provider. The on-site manager for the service met weekly with the housing provider. People who lived in the accommodation were invited to a residents meeting where staff from the service were also invited to attend and listen to people's comments.

We saw the provider had carried out a survey in March 2017 to monitor the quality of the service. Thirteen people had responded to the survey and we saw the aggregated survey results were mainly positive. We spoke with people who used the service and they confirmed they had completed the surveys. One person told us they were not always happy with the support they received. We asked the person if managers acted on the feedback that they received, the person said they did not think so as nothing has changed since they gave their feedback. One person told us the carer had completed the questionnaire for them without their consent and they felt this was the wrong thing to do. We found such actions as described by people who use the service calls into the question the validity of the survey results.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider was failing to do all that was reasonably practicable to mitigate risks to service users.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The register provider failed to ensure there was an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. The registered provider had failed to implement and embed an effective system to quality assure the service they provide.