Real Life Options

Real Life Options - Stacey Drive

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

The inspection took place on 25 November 2014 and was unannounced.

Stacey Drive is three, interconnected bungalows, where care and support is provided to up to 12 people who have learning and/or mental health needs and who need support to live in the community. There were ten people living in the home at the time of the inspection.

At the last inspection, in November 2013, we found that there were enough qualified, skilled and experienced staff to meet the needs of the people in the home. However, there were not sufficient numbers of suitably qualified staff to carry on the regulated activities for which the home was registered. The home was registered for

Summary of findings

nursing at that time and there were not sufficient numbers of nurses employed. The home is no longer registered to provide nursing care and there is no-one in the home who requires nursing care.

At the time of this inspection there was no registered manager. The home was being run by a manager who was in the process of applying for registration. This manager also managed two other services, one in Birmingham and one in Coventry. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us, or indicated by gestures, that they were happy at this home. They provided examples of when they had been to places of interest or been supported to do things they enjoyed. We saw staff treating people with respect and communicating well with people who did not use verbal communication. However, we saw examples of staff not following the instructions in people's care plans, for example during meals, and this placed people at risk.

At this inspection we found that some areas of the home were not sufficiently clean, with food spillages and stains in places. The carpet in one bungalow was worn and stained. The provider had no clear systems in place for ensuring that the home was clean and this meant that there was a risk of infection spreading and people were not fully protected.

We spoke with some newer staff who told us that they had shadowed more experienced staff and they had some knowledge about people who lived in the home. This did not mean they had the knowledge or skills needed to meet the complex situations that may have arisen in the home. Although more detailed training was planned, this had not yet been delivered. We found enough staff to cover people's basic needs but found that staff were not always deployed to ensure that people's needs were met. There were not enough staff to accompany people should several have chosen to go out of the home and this restricted people's choices.

The provider had not taken action to ensure that people not put people at risk of receiving inappropriate care and support.

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

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care. This includes decisions about depriving people of their liberty so that they get the care and treatment they need where there is no less restrictive way of achieving this. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty. We spoke to staff and looked at records to see of the home was complying with this legislation. We found that the manager and staff had not received training in relation to recent interpretations of this legislation and they demonstrated no understanding of the impact on people at the home. This meant that people's human rights were not being fully protected.

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

Requires Improvement

People were not always safe.

Although people said they felt safe they were at risk of infection due to poor arrangements for ensuring that the home was clean.

There were good arrangements for the identification and referral of safeguarding concerns and the manager reported incidents appropriately.

Staff were recruited appropriately and there were sufficient numbers of staff to meet people's basic needs.

People received their prescribed medication safely but arrangements for recording and managing all medications were not undertaken in line with relevant guidance.

Is the service effective?

Requires Improvement

The service was not effective.

Newer members of the staff team had not received structured induction training which meant people were at risk from staff who did not have the skills and knowledge to meet their needs.

Arrangements for the deployment of staff on each shift were unclear and this meant that people were not supported at all times in a consistent and skilled way.

People were supported to attend medical appointments and staff sought advice from health professionals in relation to people's care.

Not all people were being supported to eat and drink in ways which maintained their health or safety.

The manager and staff had not received up to date training in relation to the requirements of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). This meant that people were at risk of having their liberty restricted unlawfully.

Is the service caring?

Good

The service was caring.

People were happy with the support they received. We saw good and kind interactions between staff and people who lived in the home.

People were involved in planning the support they received, if they were able, and were supported to be as independent as possible.

Staff demonstrated that they respected people's privacy.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

There were good systems for planning the care and support which people needed but this information was not easily available for all the people in the home.

People's comments and complaints were listened to and appropriate changes were made in relation to complaints.

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Is the service well-led?

Requires Improvement

The service was not well led.

There was no registered manager at the home. The manager was managing other services and there were no suitable arrangements for cover in her absence.

The systems for audit and quality assurance were not sufficiently robust and were not being used consistently enough to ensure safe and appropriate support to people.

There were some links with the local community as relatives were encouraged to visit, but opportunities for community involvement were limited by staffing numbers.

Real Life Options - Stacey Drive

Detailed findings

Background to this inspection

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

This inspection took place on 28 November 2014 and was unannounced. There were two inspectors involved in the inspection of this home. At the previous inspection, in November 2013, we found that the home provided a good standard of care and support.

Before the inspection we looked at the information we held about the home, including information which had been provided by people who had contacted us with concerns, social workers and representatives of Birmingham City Council's commissioners.

Before our inspection we checked the notifications we had received about the home. Providers have to notify us about some incidents and accidents that happen in the home such as safeguarding concerns and serious accidents. We checked to see if we had received any comments about the service since our last inspection and spoke with the local authority commissioning service about their involvement with the home. We used this information to plan what areas we were going to focus on during our inspection.

During the inspection we met nine of the ten people living in the home. We observed the care of people and spoke with one person's relative. We asked questions of five members of staff and the acting manager of the home. We looked at records in the home including those associated with medication, quality assurance and staffing. We looked at a sample of four people's care plans. We spoke over the telephone with three health and social care professionals who visited home and with two relatives.

Requires Improvement

Is the service safe?

Our findings

People were not provided with a clean and safe environment to live in because staff did not take appropriate action. Staff told us that cleaning tasks were carried out by all members of staff. There were no dedicated housekeeping staff and there were no clear arrangements about who should clean and when. We saw the paintwork and the radiators in some areas, such as one of the dining rooms, was dirty and had stains on them. There were stains and spillages on furniture and radiators in dining areas and the carpet in one bungalow was heavily stained indicating that these areas had not been cleaned. Several drawer fronts in kitchens were missing or damaged making it difficult to keep these areas suitably clean. The provider did not have robust arrangements for keeping the service clean and hygienic to ensure people were protected from the risk of acquiring an infection.

The lock on the cupboard where cleaning materials were stored was broken so staff had removed the contents to the garage pending a repair which was expected the next day. However, the key was in the garage door at the time of our visit so people could have accessed these materials. The temporary arrangements for the storage of cleaning materials were not ensuring the safety of people at all times. The issue of the key being left in the lock was brought to the attention of the staff who immediately removed it.

These issues demonstrated a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People who were able to talk to us told us that they felt safe in the home. Other people looked relaxed in the company of staff. In conversation, staff demonstrated that they were aware of the signs of possible abuse of people and they knew what action to take, should they suspect that someone was being abused. The manager explained that, when interviewing prospective new members of the staff team, she asked questions about safeguarding to test people's awareness of the relevant issues. Since the last inspection, six matters have been brought to our attention regarding events which were reported to the local authority for investigation under the safeguarding arrangements. These had been reported by the manager or staff of the home and this showed that the manager and staff were aware of the procedure to follow when there were incidents or allegations.

Staff told us that they had been recruited through a system which included a standard application form, interviews, references and checks through the Disclosure and Barring Service. This meant that there were good arrangements for protecting people from staff who were known to have posed a risk to them.

We received comments from professional visitors and relatives that it seemed that there may not be enough staff to meet the needs of people in the home. Since our last visit, the manager and several members of staff had left the team. New staff had been recruited and use was made of agency staff to ensure that there was cover at all times. People's needs had been reassessed by social workers and there had been some changes to the number of staffing hours which had been commissioned. We found enough staff to cover people's basic needs but found that staff deployment meant that they were not always available to support people to follow individual pursuits or interests.

We looked at the way medicines were stored, administered and recorded. Medicines were only handled by staff who were trained to do so. There were suitable facilities for storing medicines. The records for each person's medication contained a photograph of the person and instructions for staff to explain when to give medicines which were prescribed 'as required'. The records of the administration of medicines were completed by staff to show that all prescribed doses had been given to people. We saw that medicines were administered by two members of staff. People received the medicines which had been prescribed for them in the correct doses.

We looked in the controlled drugs register. This register had not been checked recently and contained many errors, however the medication recorded in this register was not a controlled drug. There were other records which indicated to us that the person had received the correct medication so we were assured that no-one had been placed at risk through these errors in records. We made the manager aware of this and she said that she would address the matter with the relevant members of staff.

Requires Improvement

Is the service effective?

Our findings

People who required it were not receiving consistent support to eat and drink. We observed as one person was served a meal and ate it. The member of staff left the room whist the person ate. We later looked in that person's records and saw that they had been assessed by health professionals as being at risk of choking. They had been told not to eat certain foods and the guidance said that a member of staff should accompany the person whilst they were eating. This meant that the person had been placed at risk of choking. This risk was brought to the attention of the manager who took immediate action to prevent the risk being repeated. One person's records indicated that they required a fortified diet, but staff could not demonstrate that this was being implemented. The provider had failed to ensure that arrangements were in place to ensure that staff were aware of the individual risks and support needs of people living at the home.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty.

We asked the manager if she was aware of the recent supreme court ruling in relation to the Deprivation of Liberty Safeguards (DoLS). She was aware that there had been a ruling but neither she nor any member of the staff team had received training in this area. We saw some assessments of people's capacity to make decisions in various areas and records of decisions which had been made by professionals in people's best interests. However, there were no recent assessments of people's capacity to make decisions or any record of the areas in which people may have been being deprived of their liberty. Within the home people's movement was not restricted. On the day of the inspection we saw that some people were moving freely between rooms and between the bungalows, choosing to sit in living-rooms which were not in the bungalows where their bedrooms were.

No-one complained to us that they had been prevented from leaving the home but we noted that some people were clearly not able to leave the home on their own and would have been at risk in the community had they done so. No applications had been made to the relevant authority in relation to this matter.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that staff appeared to have no clear plan of what they would be doing on the shift, or of what roles each person would play. Staff told us that they decided between them who would do what and, although based in one bungalow at the beginning of each day, they sometimes needed to move between the bungalows in response to the needs of people living in the home. Although this meant that staff could respond to the changing needs of people in the home, there was no guarantee that essential tasks would be carried out.

Newer members of staff had not been provided with structured induction training. The manager confirmed that only one of the several newer members of staff had received the provider's induction training. Staff told us that they shadowed more experienced colleagues when they first came to the home but they had not completed the induction training workbooks. This meant that staff did not receive specific training that the provider had determined was needed to support people adequately. We found that there had been a high turnover of staff and some staff did not have any prior experience of working with people who had complex needs and dealing with the risks that could arise in day to day situations. Staff told us that the manager could not be available at the home every day due to her other management commitments, but they could usually contact her by telephone if they needed to do so. There was a plan for supervision and training of staff on a regular basis but, due to a high recent turnover of staff and a lack of management time, not all staff had received the training or supervision that had been planned.

Relatives told us that people were supported to attend hospital and other health appointments. For example, One person told us, "If (relative's name) complains about toothache, they make an appointment with the dentist." However, one relative told us, "They should call me if anything changes like their health, but they don't do that." We found evidence that people had been supported to attend a range of health related appointments in relation

to their routine and specialist needs. This helped to keep people as healthy as possible. Some people were experiencing age related conditions and staff had accessed relevant professional support to meet their needs.

People were supported to exercise choice and ate meals at different times in accordance with their own choices. People told us that they enjoyed the food and could choose what they ate. A relative told us that their relative seemed to be happy with the meals. We asked staff how they knew what to prepare, or support people to prepare, for each meal. They told us that they looked in the fridge/ freezer and asked people what they wanted. We saw that staff had recorded the meals which people had eaten in their daily records. The records contained checklists for staff to record the number of fruit and vegetables which people had eaten each day in order to ensure that people would eat at least five portions a day. These records showed that most people rarely ate five portions of fruit and vegetables and there was no indication that staff had made efforts to encourage people to eat a more healthy diet.

Good

Is the service caring?

Our findings

People who lived at this home told us that the staff were caring. They provided examples of times when they were happy. For example, one person told us, "It will be my birthday soon. We have good birthday parties here." One person said of a member of staff, "He's a good bloke, he is."

Relatives told us that there were caring staff at the home. One said, "They seem to like (relative's name)."

Relatives of people in the home told us that people had good relationships with members of staff who were their key workers but they expressed concern that they had received letters explaining that the number of care hours had been reduced following assessments which, they thought, had been carried out by the commissioners of the service.

We saw staff communicating well with people. Some people were able to talk to staff and explain what they wanted and how they felt. Others needed staff to interpret gestures or understand the person's own methods of communication. We saw that staff were be able to communicate with people. People's plans contained person centred guidance for staff about how to communicate. We saw guidance including, 'I do understand sentences – you may at times need to repeat sentences' and 'Speak clearly, give me eye contact'.

Some people had been out to various places in interest and on holidays that they had chosen. A relative told us, "They do go out for meals. They do ask (relative's name) and they say 'yes'."

Some people wanted to show us their rooms, where they had items relating to their interests. They told us that they were encouraged to be as independent as possible in keeping their room tidy and clean. They said that staff supported them to make drinks and to help with cooking.

People made choices about what they wanted to do and where they wanted to be. We saw people walking round between the bungalows to visit other people who lived in the home. People ate meals at different times according to choice.

Relatives told us they thought that the manager was a caring person but they would have preferred her to be at the home on a full time basis in order to be able to manage the staff team.

Staff demonstrated that they respected people's privacy by, for example, knocking on doors and asking people's permission before going into rooms.

Requires Improvement

Is the service responsive?

Our findings

People told us that they could choose how and where they spent their time. One person explained to us. “I am staying in today because it’s too cold to go out.” We saw that some people were moving freely between rooms between the bungalows, choosing to sit in living rooms which were not in the bungalows where their bedrooms were.

People who lived in this home told us they sometimes went out for meals and further afield such as a shopping trip to Manchester and holidays. One person said that they liked to go to a local café. On the day of our visit one person was out of the home and the rest of the people were either watching television, talking with staff or with visitors or they were in their own rooms.

One person’s plan advised staff that the person ’thoroughly enjoys going out on the buses or any other form of transport’ and ‘want to be able to go out on activities every day’. According to the records, this person had ‘relaxed in the living room’ of one of the bungalows every day in November except for two occasions when they went out. This meant that staff were not responding to their preferences and providing support for the person to follow their own interests.

The home had good systems for person centred planning. Each person’s plans had been drawn up following consultation with relatives, where appropriate, and relevant health and social care professionals, taking note of the person’s wishes and aspirations. Plans contained details of the choices which people had made in relation to their lifestyle and details of their needs based on their culture and religion. The information gathered had been transferred to ‘one page profiles’, which could provide newer members of staff with an overview of the person’s needs and preferences. These were displayed on the office wall for quick reference. There were ten people living in the home at the time of our visit and there were only seven profiles displayed. This meant that this overview information, although useful, was not readily available in relation to all of the people for newer members of staff to refer to.

People told us that they could go to the manager if they wanted to complain about anything. Relatives told us that the manager made herself available and was receptive to comments. Relatives told us that they felt able to raise issues with the manager and had confidence that she would act, should they raise concerns. One relative said, “She is always at the end of the phone if we need her.” The manager demonstrated how she had dealt with complaints and comments, making changes when appropriate and the records confirmed that there were good systems for handling and responding to complaints.

Requires Improvement

Is the service well-led?

Our findings

One person told us of the manager, "She is a lovely woman but she can't be here all the time, she needs to be here to manage." At the time of this inspection there was no registered manager The previous registered manager of this home left the service and was voluntarily deregistered in June 2012. The home was being run by a manager who was in the process of applying for registration. This manager was also managing a service on the other side of Birmingham and services in Coventry at the time of our visit. People expressed a view that there were insufficient numbers of staff to provide a safe and consistent service and some expressed concern that there was no consistent management presence.

Although there were systems to assess the quality of the service provided in the home we found that these were not always effective. The systems had not ensured that people were protected against key risks in relation to inappropriate or unsafe care and support and management of risks.

The manager told us that home's quality assurance systems included audits which were carried out every three months. However, the most recent audit we could find was dated December 2013. The manager explained that she had identified some shortfalls in the records and practice and had made some improvements since coming into post but she had to share her time between the three services she was managing so did not have sufficient time in the home to complete regular audits. The manager advised that additional support from a team coordinator for audits to be carried out was not adequate to enable all essential audits to be undertaken. The manager advised that there were no senior members of staff to whom she could delegate responsibilities.

We saw that people had some opportunities for maintaining links with the wider community. For example, relatives were encouraged to visit and people attended facilities outside the home for leisure and recreation. However, opportunities for outings and further community involvement were less frequent than at the time of our last inspection. Opportunities for community involvement were limited by staffing numbers. We were advised that the home was also due to lose the use of its minibus shortly after our visit.

We sampled four people's care plans and health records. We found several examples where plans and action plans contained a statement that they would be reviewed annually but there were no dates on the original plans so it was not possible to tell when a review was due. We found several sheets in people's plans which stated that 'all staff should sign here to indicate to say they know what to do to support me'. These were, in some cases, signed by a minority of staff members and in some cases not signed by anyone. We found some cases where entries in records had been signed by staff entering their initials, but there were no sheets with samples of initials so it was not possible to find out who had made the entry.

We found errors which could have led to a person receiving incorrect treatment. For example, in one person's hospital passport, which is the document they would take to hospital with them, we noted that a spelling in the section 'Things you must know about me' was incorrect due to a spelling error and would have led to confusion and a possibility that the person would receive incorrect treatment in an emergency. We established with the manager what the correct condition was and the manager made the necessary changes. The providers systems for checking the records were not robust and could have led to a person receiving incorrect and unsafe treatment.

When we arrived at the home we met two members of staff who informed us that the manager was not on the premises but had been in the home earlier that day. When we asked who was leading the shift, they were unsure. We looked at the home's rota and saw that there was no identified shift leader or person in charge in the absence of the manager. The manager arrived at the home during our visit and informed us that the person in charge of each shift was the member of staff who carried the main bunch of keys. The manager explained that there was only one 'team coordinator' and no senior members of the staff team so it was not possible to cover each shift with a senior member of staff to take charge. Although the manager was contactable by telephone, there was no designated, experienced person in charge in the home.

These matters were a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us that the manager of the home was approachable and helpful. People living in the home seemed comfortable in her company and communicated

Requires Improvement

Is the service well-led?

with her with ease and familiarity. Staff told us that the manager made herself available when they needed advice and could be contacted at most times when she was away from the home.

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 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment People could not be confident that deprivations of their liberties would be identified or appropriately referred on by staff working for the service.

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 You were not regularly assessing and monitoring the quality of the services provided in order to protect people from the risks of inappropriate or unsafe care and treatment.