

Ordinary Life Project Association(The) Ordinary Life Project Association - 15 Mossmead

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

This inspection took place on the 7 July 2016 and was unannounced. At the previous inspection visit which occurred in January 2014 all standards inspected were met.

Three people were currently living at the service which is registered to provide accommodation for up to four people with learning disabilities.

A registered manager was in post but working reduced hours. The senior support worker was given additional responsibilities in the day to day management of the home. '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.'

Mental Capacity Act 2005 (MCA) assessments were not always undertaken for specific decisions and relatives without legal powers to make best interest decisions were able to consent to care and treatment. For example, for family members without legal powers were able to undertake intimate checks. This meant some decisions were not legally authorised.

Deprivation of Liberty Safeguards (DoLS) applications to the supervisory body for continuous supervision were in progress for people living at the service.

Support plans lacked a person centred approach and were not up to date. Life stories were not part of the support plans. The person we asked confirmed there was a care file that that contained information about their needs and told us the information kept in their file was explained to them.

Quality assurance systems were not fully effective. Records were not up to date and were not reviewed regularly. The Providers visits were not regular and it was evident from the house development plan dated 2011 that there was a consistent theme for improving care planning, updating health action plans and increasing activities. People and staff had made suggestions for more one to one time with people. However, there was little improvement.

Staffing levels were arranged to provide one to one time with people. However, there was lone working during the week and at weekends. This meant during these periods activities for people to access were limited.

The person we spoke with said they felt safe living at the home. They said the staff and other people made them feel safe. The staff attended training in safeguarding adults from abuse. The staff we spoke with were able to describe the procedures for safeguarding people from abuse. These staff described the types of abuse and the action they must take for suspected abuse.

Risks were assessed and action plans were in place to minimise the risk. Members of staff had a good understanding on the potential risk to people and the impact they had on the person's safety. Reports of accidents and incidents were completed and from the analysis of the reports patterns and trends were identified.

New staff received an induction when they started to work at the service. Staff attended training that helped them develop skills and insight into the needs of people. One to one meetings with staff's line manager happened every eight weeks. At these meetings staff discussed areas of concerns and training needs. However, relief staff working regularly at the service did not benefit from having one to one opportunities to discuss their personal development. Staff said the team worked well together.

People were supported by staff with their ongoing healthcare needs. People were accompanied by staff on healthcare appointments. People had access to specialists and they had regular dental and optician check-ups.

People's dietary requirements were met and they were involved in menu planning. We saw people ask for refreshments and snacks between meals and the staff responded to these requests.

The person we asked told us the staff were "caring." We saw good interaction with staff. The staff we spoke with had a good understanding of people's preferences and how to develop positive relationships.

The complaints procedure was in pictures and words and copies of the procedure were kept in people's care files. The person we spoke with said they would approach staff with concerns. A member of staff told us the complaints procedure was discussed with people at tenants meetings.

We found 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 this 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?

Good ●

The service was Safe

Risks were assessed and staff showed a good understanding of the actions needed to minimise the risk to people. Sufficient levels of staff were deployed to meet people's needs.

Safe systems of medicine management were in place. Staff signed medication administration charts to show they had administered the medicines. Protocols were developed for administering "when required" medicines.

The person we asked said they felt safe living at the service. Staff knew the procedures for the safeguarding of vulnerable adults from abuse.

Is the service effective?

Requires Improvement ●

The service was not fully effective

People were assisted by staff to make day to day decisions. People's capacity to make specific decisions was not always assessed. Relatives were given consent to undertake checks at the home with staff present.

Staff had access to a range of training to ensure they had the correct knowledge and skills to provide people with care and support to meet their needs.

People had a choice of food and drink and they received sufficient to meet their needs. People spoke positively about the food choices available to them.

Is the service caring?

Good ●

The service was caring

One person said the staff were caring. We observed good interaction between staff and people.

Members of staff were seen spending time with people in shared

spaces. We saw them discuss with people the tasks they were about to undertake.

Is the service responsive?

The service was not fully responsive

One person said a care file about them was kept and staff explained what was written about them. Support plans were not up to date and were not person centred as they did not give staff direction on how people liked their care needs to be met

There was an activities programme in place and there were opportunities for one to one and group activities. Activities for people were limited.

The person we spoke with said they would approach the staff if they had concerns.

Requires Improvement ●

Is the service well-led?

The service was not fully well led

The provider did not have effective systems in place to assess, monitor and improve the quality of care. There were recurrent themes about reviewing care plans and increasing activities but there had been little improvements.

Systems were in place to gather the views of people and their relatives. An action plan was developed to improve the service people received.

Members of staff worked well together to provide a person centred approach to meeting people's needs.

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.'

This inspection took place on 7 July 2016 and was unannounced.'

The inspection was completed by one inspector. 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.' We also reviewed information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

During the visit we spoke with one person, two staff and the registered manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent time observing the way staff interacted with people who use the service and looked at the records relating to support and decision making for two people. We also looked at records about the management of the service

Is the service safe?

Our findings

The person we spoke with said they felt safe living in the home. They said the staff and the other people living at the home made them feel safe. The two other people we observed were friendly and cheerful when they were spending time with staff. Members of staff showed a good understanding of the safeguarding of adult's abuse procedures. They knew the types of abuse and the actions they must take if they suspected abuse was taking place. A member of staff said in the past they had made referrals for alleged abuse to the lead authority for safeguarding people from abuse. Another member of staff said they would report poor practice they may witness from other staff. They were confident that their concerns would be investigated.

Arrangements were in place to manage risk. A member of staff said risks were assessed to ensure people were able to take risk safely and to ensure the risk to people's welfare was minimised. Another member of staff described the potential risks to people. For example, risk assessments in place ensured equipment and the premises were safe for people and staff who lived and worked at the service. Risk assessments were devised where risks were identified. An action plan was then developed on how to minimise the risk to the person. For example, the risk assessment for one person with visual impairments had identified a potential risk when visiting unfamiliar places and other people. The action plan was to ensure there were consistent staff available to support the person.

Risk assessments were devised for another person with diabetes and who was at risk of choking. The risk assessment action plan to manage diabetes listed the steps to support the person to maintain their health. For example, they followed a low fat diet and guidance was given to staff on the acceptable blood sugar range. The action plan to prevent the person from choking listed the foods to be avoided and texture of foods to be served.

Reports of accidents and incidents were completed. A reflective log was also completed by the staff to promote learning and decrease a reoccurrence of incidents. Copies of the accident and incident forms were used by the provider to assess patterns and trends.

One person told us they had one to one time with the staff. A member of staff said there had been changes of staff but recruitment of new staff was in progress. Another member of staff said there were two relief staff covering vacant hours. They said the staffing rota was devised for people to have one to one time with staff. For example, the person at home had opportunities for one to one time with staff when other people were participating in outside day care activities. Where three people were at the home, where possible, two staff were on duty to offer activities. The rota in place showed two staff were on duty between 10am and 6pm and at all other times one member of staff was on duty including at night. At weekends there was one member of staff on duty which meant activities at weekends were limited.

A member of staff explained the arrangements in place for using agency staff. They said agency staff working at the service had to be competent and have skills to meet people's needs. For example, they had to be competent to administer medicines. A file with essential information on caring for people had been devised for relief and agency staff. Within the file were people's profiles and procedures such as on-call and

emergency evacuation procedures.

Medicine management systems in place were safe. One person told us the staff administered their medicines. Medicine profiles gave staff guidance on the medicines they were administering which included the purpose of the medicine. Protocols were in place for medicines administered "when required" (PRN). For example, PRN protocols for pain relief detailed the purpose of the medicine and the maximum dose that staff could administer in a 24 hour period.

Medication Administration Records (MAR) charts were signed by staff to indicate the medicines administered.

Is the service effective?

Our findings

"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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met."

People's capacity to make specific decisions was not always assessed. For example, assessments were not undertaken for blood sugar testing and for removing facial hair. We found people's consent to care and treatment was not consistently sought in line with the MCA 2005.

Capacity assessments were not undertaken to test blood sugar and to remove facial hair. The removing of facial hair risk assessment dated 22 March 2011 listed the control measures to be followed by the staff. For example, risk of refusing and for staff to use an electric razor or hair removal cream. Best interest decisions were not reached and action plans developed on how the person was to be supported. For example, an action plan for best interest decision was not in place for staff to administer non-insulin injections to one person with diabetes.

The MCA assessment for one person had identified this person lacked the understanding necessary to make the decision regarding their healthcare screening. It was recorded the person lacked capacity to make decisions about breast screening. A decision was made for a family member of undertake the breast examination at the service in the presence of the staff. We did not see evidence of a best interest decision taken place for the relative to undertake the checks.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living at the home were subject to Deprivation of Liberty Safeguards (DoLS) for continuous supervision. DoLS applications to restrict people's liberty were made to the supervisory body for approval.

The person we spoke with said they made decisions about what to wear. Members of staff had an understanding of the principles of the MCA 2005. We observed staff enabling people to make decisions about where to sit, activities and meal choices. A member of staff said people made day to day living decisions which included what people wore, the activities they wanted to access and meal preferences. They said one person had blood sugar tests which the staff carried out and if this person refused they would

use scenarios to help the person understand and gain consent for the test. It was stated "we try a different way, we can't force."

A member of staff said the people at the service sometimes were aggressive towards each other. They said input from behaviour specialist was sought to develop guidelines and strategies on how to support people to manage these behaviours. Risk assessments were developed on how staff were to manage conflicts between the three people at the home. The behaviour support action plan dated 2011 and reviewed in 2014 for one person listed the steps staff must take to prevent an incident from escalating. For example, staff were to encourage the person to listen to music, give space for them to regain control of their behaviour and staff were to complete charts that helped staff identify triggers to aggressive behaviours.

A member of staff said new staff received an induction to the home and the organisation and were registered onto the care certificate programme. They said the induction was six months and covered familiarisation of the building, essential training set by the provider and reading procedures. For example, moving and handling, first aid, safeguarding adults from abuse and infection control.

Another member of staff said "holistic care planning" training was recently attended. They said the training was to assist staff to "look at issues around risk and supporting people to develop skills." The training plan in place listed the dates and the type of training to be provided with the names of the staff that will be attending.

A member of staff said one to one meetings with their line manager occurred eight weekly for permanent staff and monthly for new staff on their induction. They said at the one to one meetings they discussed the keyworker [member of staff assigned to specific people] role, training needs and staff issues. Performance was to be included to the one to one to ensure staff were fulfilling their roles and responsibility.

A relief member of staff said because of their status they were not having one to one meetings with the line manager. This meant there was a lack of opportunity for relief staff to review their personal development and progress.

People's dietary requirements were met. One person said staff prepared the meals and prepared refreshments and snacks. The range of fresh, frozen and tinned foods at the home ensured people were supported to have adequate food and fluid to maintain good health. A member of staff said menus were developed on Sunday with people. They said pictures were used to help people make meal suggestions.

The menus were based on the tea-time meals as people ate their breakfast and lunchtime meals independently. as people selected their preferred breakfast and lunchtime meal. The member of staff said people participated in meal preparation. During the inspection we saw one person having eggs on toast for breakfast and staff responded to people's request for snacks and refreshments in between meals.

People were supported with their ongoing healthcare needs. The person we spoke with named the staff that accompanied them on healthcare appointments. Records of healthcare appointments with the outcome of the visit were maintained. People saw their GP regularly, had input from specialists such as psychiatrists and had check-ups with the dentist and optician. Health Action Plans were developed from the GP's annual health check-up. An action plan to meet people's healthcare needs was not developed from the check-up.

Hospital passports had important and essential information about the person for medical staff in the event of an emergency. People's contact details, medications and brief history were included in the passport. The

things that were important to the person for example, eating and drinking preferences, personal care and pain management were also included in the hospital passport. However, the information was not up to date. For example, the current medicines were not included in the hospital passport. A member of staff told us "grab" packs were to be developed with relevant information about the person. They said "this will ensure emergency medical staff have the most appropriate information."

Is the service caring?

Our findings

The person we spoke with said the staff were caring. They also told us they discussed menu planning at their meetings.

We observed staff and people interacting with each other. Members of staff sat with people and discussed the activities to take place and the meals to be served. We saw staff sit with people and share their lunch. One person made the decision not to eat with other people. One person invited us into their bedroom and we saw their personalities reflected in the décor and personal belongings. For example, personal items, photographs and arrangement of furniture within the bedroom. Another person spent their day in the summer house that was decorated with bunting and we saw the person engaged with the games kept in the summer house.

A member of staff said relationships with people were developed slowly. They said "try to understand each other, finding people's preferences and having conversations with people about the friends and families who are important to them. Developing trust helped to gain agreement for staff to undertake tasks" It was explained knowing people's likes and spending time with each person helped to develop positive relationships.

Another member of staff said developing person centred plans with the person helped the individual understand their care and treatment. They said training and one to one meetings with staff enabled positive relationships to be developed.

Life stories were not developed. This meant that staff were not provided with an overview of the person's family and their history before their admission to the service.

We found "About Me" and daily routine care plans in people's care records. "About me" documents listed people's personal details and daily routine. Care plans described how the person spent their day. For one person their evening routine care plans listed the steps needed to achieve the routine. However, the person's preferences on how the staff were to assist them with their routine was not recorded. We saw stated for one person "XX will make decisions on the personal care. The person has capacity to achieve routine and the support needed from the staff."

The person we spoke with said the staff "knocked on bedroom doors before entering". Staff respected people's rights. A member of staff said they respected people's decisions. For example, one staff member told us "if people were to refuse to have their hair washed. It's not the end of their life not having their hair washed." An example which included closing doors while delivering personal care was also used to explain how people's privacy was respected.

Is the service responsive?

Our findings

The person we spoke with confirmed they had a care file and that the staff explained to them their support plans. The relief staff on duty told us they were not involved in developing support plans. The permanent member of staff explained there was an expectation keyworkers [member of staff assigned to specific people] developed and reviewed the care plan. They said support plans were to be reviewed and the arrangements to review them were discussed at team meetings.

Support plans lacked a person centred approach. Support plans did not include people's preferences, the aspects of care the person was able to manage for themselves and the guidance to staff on how they can support people to achieve the objectives. For example, the hair care support plan states "XX will have her hair washed daily. She has her hair washed in the bath or shower. Staff support to rinse her hair."

Support plans were not always up to date. For example, the Emotional Needs and Emotional Understanding support plan detailed the behaviours exhibited by the person and the impact this had on other people. However, the support plan had not been reviewed since January 2015. The weekend support plan for another person had not been reviewed since it was developed in 2011.

Person Centred Plans (PCP) to assist people on planning for their life were basic and action plans were not devised on how to assist the person to achieve their goals. For one person an action plan was not developed for the goals identified which included developing communication, increasing day time activities and reviewing health action plans.

The person we spoke with told us they went on trips out with the staff, attend day care centres and joined their relatives for meals. A member of staff said a plan of activities was in place and staff used pictures to discuss with people their preferred activities. They said staff were to develop individual activities programmes with people using the service. The activities rota for one person included weekly one to one time with staff, attending clubs and going shopping. We saw recorded in questionnaires that two people had requested for an increase in activities.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Epilepsy profiles were in place for people that experienced seizures. Profiles were reviewed by healthcare professionals and gave staff guidance on the actions they must take for the type of seizure.

Staff said there were handovers when they arrived on shift. A member of staff said the handover took half an hour to discuss issues that happened before they came on duty. They said handover sheets were completed and gave them information on results of tests, appointments and important events. The handover sheet for the day of the inspection included the audit of medicines carried out, records of food and fluid intake, blood sugar results, and appointments. Individual diaries were used to record the times when people woke up and went to bed and activities undertaken.

The person we spoke with said if they were not "happy" they would tell the staff. No complaints were received at the home. Visitors to the home were asked to complete feedback forms about the home. Feedback was received from agency staff and action was taken. For example, the codes to be used when dialling out on the office phone. .We saw copies of the complaints procedure which was in pictures and words format stored people's care records.

Is the service well-led?

Our findings

The provider information record (PIR) stated "The SU's [service users] have detailed support plans, HAP [Health Action Plans], PCP Person Centred Plans], Hospital passport, Living Well. Likes and dislikes, personal preferences and preferred support needs are documented." However, these documents had not been reviewed and were not up to date. Records such as care plans and health action plans were not up to date.

Questionnaires were used to gain feedback about the service from people and their relatives. The views of people and their relatives were positive and one relative's view was that the service was excellent. Two people had identified activities as an area for improvements. We saw from the house development plan dated 2011 that developing activities has been a recurrent issue for people.

The views of staff about the service were also gathered using questionnaires and at staff meetings. Questionnaires targeted feedback on specific topics for example, dignity. Staff suggestions for improvements included more one to one with people, to develop a history book and for staff to attend training on a holistic approach. Staff meetings were monthly and at the most recent meeting care planning, activities and hospital grab bags were discussed. While issues for improvements had been identified and were consistent with the inspection finding, it is evident care planning and activities have been a recurring theme but improvements have been inconsistent.

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

The standards of care and treatment were assessed by a quality assurance team which included an area manager, Human Resources (HR) personnel and the Chief Executive. During the quality assurance visit report dated 29 October 2015 the environment was assessed. An action plan of repairs to take place was devised.

A member of staff said the team worked well together, the atmosphere was good and the staff were working at the home for the benefit of "the ladies" that lived at the service. They said "it's great, we try and take the ladies out. We know the jobs that need to be done and they are shared." Another member of staff said the principles of organisation were based on "normal and what would happen anyway. It's like a sleepover with the girls."

A registered manager was in post. The registered manager and staff said the registered manager worked reduced hours. The senior support worker was given additional day to day management responsibilities from May 2015 which included improving the quality of care people already received. The senior support worker told us they would not be able to ask the staff to undertake any tasks they were not prepared to undertake themselves.

Internal audits were undertaken to assess and monitor the quality of the service. For example, medicine and infection control. The Medicine audit dated June 2016 showed that where medicine errors had taken place

an action plan was developed to prevent any reoccurrence. Infection control audits focused on specific tasks to be completed and were audited three monthly.

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
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Support plans were not reviewed and lacked a person centred approach.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's capacity to make specific decisions were not always assessed. Relatives without legal powers to care and treatment were able to undertake intimate checks at the home with staff present.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records were not reviewed and were not up to date. For example support plans and health action plans. There was a recurrent theme for staff to review support plans and to increase activities.