Agemco Limited

Capricorn Cottage

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

The inspection took place on 14 January 2015 and was unannounced. The home was last inspected in January 2014 and was found to be meeting the regulations we inspected.

The home is registered to provide care for 34 people who lived with learning disabilities or autism and for older people living with a dementia. The home is a single storey building with the majority of the building accommodating people living with learning disabilities or autism. Within this area of the home is a kitchen/dining room area where people could be supported to be more independent. At one end of the building through a secure door was a four bedded unit for people living with dementia. This unit had all the facilities people needed to live including a kitchen area and a lounge/dining area, bathroom and access to secure outside space. There were 26 people with learning disabilities living at the home and four people in a separate unit living with dementia. There was a registered manager at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found a number 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 this report. We found there were not always enough staff and staff training was not effective and did not ensure people were safe. Systems to monitor the quality of service provided had not identified shortfalls in care.

Staff had not fully understood what constituted harm to people. Although some concerns had been raised with the manager appropriate action to keep people safe had not been taken. There were not always enough staff available to ensure people received their support in a timely fashion.

Some risks to people while receiving personal care had been identified and appropriate actions had been taken. For example, people had been helped to keep their skin heathy by using soft cushions and mattresses that reduced pressure on key areas and systems ensured medication was available and administered safely. However, the risks people faced out in the community had not been included in the care plan.

The registered manager was aware of the recent changes in the Mental Capacity Act 2005 Deprivation of Liberty Safeguards and applications had been completed appropriately.

Records showed that staff had not received training in some area which would help them support people in a more appropriate way.

Mealtimes were loud and noisy and the dining room was not a pleasant place to spend time. We saw alternatives to the set menu were available for people who could communicate effectively to request them. Staff did not always listen to people's comments about the food.

While staff understood the individual way people communicated their needs and responded appropriately this was not always done in a kind and caring manner. Staff did not always support people's dignity by ensuring they were dressed appropriately.

Care plans did not support progression in people. There were no goals identified for how people could be supported to be more independent. While some activities had been provided around improving people's daily living skills, records were incomplete and did not show how effective the activities had been.

While the registered manager was available in the home they did not ensure that staff always treated people with dignity and respect. Systems in place to monitor the quality of service people received were not effective and did not identify areas where improvements were needed. There was no system in place to ensure each incident was investigated and appropriate action taken.

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?

Inadequate

The service was not safe.

Although staff had received training in keeping people safe from harm, we found that they did not always follow good practice to ensure people were safe.

Appropriate risk assessments were not always in place and did not contain information on how to keep people safe. Staffing levels meant care could not always be provided in a way which met individual needs.

Is the service effective?

Requires Improvement

The service was not always effective.

The training provided to staff did not always ensure they had the skills needed to provide care effectively.

People were supported to make decisions and had their human rights protected because the provider acted in accordance with the law.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff at times lacked the care and kindness needed to support people.

Staff were task focused and the care provided did not always meet people's individual needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always able to understand the contents of their care plans and were not fully supported to be involved in decisions about their care.

People were unhappy with the level of activities available and unsure of how to occupy themselves.

There had been no complaints received since our last inspection.

Is the service well-led?

Inadequate

The service was not well led.

The culture of the home did not always support staff to provide care in a kind and caring manner and care which fell below acceptable standards was not always recognised by staff.

The systems to monitor the quality of service people received were not adequate and did not drive improvements to the care people received.

Capricorn Cottage

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 15 January 2015 and was unannounced. The Inspection team consisted of an inspector 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 the inspection, we asked the provider to complete 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. However, the provider did not return a PIR and we took this into account when we made the judgements in this report.

As part of the inspection we spoke with the relative of one person living in the dementia unit. The expert-by-experience spoke with people in the learning disability unit and also spoke with two of their relatives. We contacted the local authority to get their views on the care provided for people. We also spent time observing the care people received and the relationship between people using the service and the staff.

We spoke with a care worker who was working on the dementia unit and two care workers and a senior care worker who were working on the learning disability unit. We also spoke to the cook, the administrator and the registered manager. We looked at one care plan for a person living in the dementia unit and four care plans for people living in the learning disabilities unit. We also looked at the medicine administration records for the home.

Inadequate

Is the service safe?

Our findings

We identified a breach in relation to how staff kept people safe. Staff told us about the different types of harm people may be at risk of and could describe appropriate actions they would take if they suspected people were being harmed. Staff said they knew how to raise concerns both to the registered manager and externally to other agencies who help to protect people. Information on how to raise a concern was available to staff in the office. Records showed that all staff had received training in how to keep people safe from avoidable harm and to protect them from bullying and harassment.

However, we observed incidents where people were not protected from harm. For example, we saw one member of staff, grab a person by their arm and pull the person towards them. The member of staff then removed the protective apron which fastened around the person's neck by pulling at the bottom of it. We found in one person's care plan an incident form which recorded a situation when a member of staff had spoken derogatively and aggressively towards a person living at the home. We discussed this with the manager who told us they had been unaware the incident had occurred and there had been no investigation of the incident. This meant the person may still have to receive care from the member of staff and be at risk of receiving further inappropriate care. We also saw one person who when leaving the table after their meal hit another person. Staff reacted to this incident by separating the people but did not take any further action. The manager told us they would investigate the incidents.

This was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safeguarding service users from abuse and improper treatment.

We identified a breach in relation to people being cared for safely. Care plans identified some risks to people and had plans in place to protect people from those risks, though, this was mainly about the physical care of people. For example, we saw where people were at risk of pressure damage appropriate equipment was in place. Bed rail assessments had been completed to ensure bed rails could be used safely and were not a danger to the person receiving care.

However, risk assessments around how to provide safe care were not always followed. For example, one person had recorded in their care plan that they were best accessing the community on a one to one basis. On one occasion they had been taken out by a single member of staff with three other people who lived at the home. The outing had been unsuccessful and had to be abandoned and as a result four people living at the service had been unable to enjoy a trip into the community. This showed the registered manager and staff did not always take into account the risk assessments in people's care plans.

Some risks were not identified and there were no plans in place to ensure appropriate action was taken to protect people from harm. For example, we saw one person liked to go out for a walk. Their care plan noted that the person could be at risk of harm while out in the community, but there was no information in the care plan about how to keep them safe. We asked two members of staff what they did to ensure the person was safe and both gave different answers. This meant the provider could not be confident appropriate action would be taken if the person did not return as expected.

This was a breach of regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 person-centred care.

We identified a breach in relation to staffing levels. Staffing levels did not always support people's needs. There was one member of staff in the dementia unit and they told us about one person who was liked to get up often and was at risk of falling. However, they said when they were attending to other people's needs they could not always monitor the person to ensure they were safe. When people in the dementia unit needed two members of staff to provide safe care a member of staff from the learning disabilities and autism unit was called to help.

Staffing levels were not adequate to support people as needed at mealtimes. We saw one person who wanted to eat immediately was served last as they needed support from staff to eat and no one was available to help them as they were busy serving other people their meals. While they were waiting they were distressed and we saw this disturbed other people one of whom was removed from the dining room as they also became upset.

Inadequate

Is the service safe?

We discussed staffing levels with the registered manager and found no tool had been used to identify people's needs and calculate the staffing levels needed to meet those needs.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 staffing.

Records showed that appropriate checks including two references and a disclosure and barring service check were completed before staff started work at the service. This meant the registered manager had completed appropriate checks to ensure staff were saw to work with the people who lived at the service.

We observed a medicine round and saw that people were supported to take medicines safely and in line with their care plan. Care plans contained information on how people liked to take their medicine. For example, we saw one person preferred to take their medicine with a spoon of yoghurt instead of a glass of water. We saw the member of staff watched to ensure people took their medicine before completing the medicine administration record (MAR).

We saw there were procedures in place to ensure all medicine received into the home was checked to ensure it was the same as the prescription. This allowed staff to chase up incorrect or missing medicine before it needed to be administered to the person.

Requires Improvement

Is the service effective?

Our findings

Although staff were supported with supervision and appraisals the training people received was not always effective and we identified a breach in relation to staff training. Staff told us and records showed that they had received some appropriate training. For example, we saw all staff had complete training in the last 18 months in infection control, health and safety and fire safety. However, we saw there were gaps in training in other areas. For example, only 57% of staff had undertaken any training in dignity and privacy, only 51% had received training in the Mental Capacity Act 2005 (MCA). We found only 14% of staff had received recent training in looking after people living with a dementia and the member of staff leading the independent living skills activities had not had any training specific to their role.

We saw staff had not received training in managing behaviour which could be challenging to others. This was important as we observed episodes of challenging behaviour throughout the day and saw that it was not always managed appropriately.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 staffing.

The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards are laws which protect people's human rights when they are no longer able to make decisions for themselves. The registered manager told us they had just completed training in the Deprivation of Liberty Safeguards (DoLS). In line with the training they had considered the mental capacity of people living at the home and had identified that a number of people required a DoLS application submitting to the local authority. These were in the process of being completed.

We saw where people were had important decisions to be made, for example about health care needs they were supported through the process. Furthermore, where people were unable to make decisions we saw assessments of their mental capacity had been completed and decisions made in their best interest involving appropriate health and social care professionals and family members. Social care professionals we contacted told us people were appropriately supported to make choices about their care.

People were not always offered a choice for their meal. One member of staff told us that people do not get asked what they would like for their main meal of the day as everyone has the same. We saw one person with more skill was able to tell staff they preferred an alternative to the main meal. However, other people who may not be able to vocalise their needs so well were not offered alternatives and relied on the cook to know their likes and dislikes. Where people required a soft diet this was presented in an appetising manner.

Where people were at risk of malnutrition they were appropriately referred to their doctor for advice and treatment. We saw some people were given special drinks prescribed by their doctor with extra calories to help them maintain a healthy weight. Food and fluid charts were completed and accurately recorded what people had eaten and drunk through the day. However, fluid charts were not totalled at the end of the day so it was not immediately obvious if people had received enough fluid.

We saw some people struggled to eat the meal as it was presented to them and two or three people refused to eat their meat.

Records showed that people were appropriately referred to the doctor or community nurse when care workers noticed a change in their needs. The home had a named health liaison nurse who visited to monitor people's health and to provide appropriate health screening.

Requires Improvement

Is the service caring?

Our findings

We found there was a breach as staff did not always treat people with consideration and their dignity, privacy and independence was not always respected. We saw that lunch was not always a pleasant experience in the unit for people with learning disabilities. The dining room was very noisy and one person told us they chose not to eat in there because of the noise. Tables were not set prior to people's meals being served. The manager told us this was because some people would move the cutlery; however instead of looking at how to support that individual all the cutlery was removed.

People we spoke with told us they were not aware of what they were having for lunch. Everyone sat and waited for food to be put in front of them and there was no encouragement or structure to support people to be more independent at mealtimes. We saw when care workers supported people to eat their meal they did not sit at the side of them they stood over them. This meant that people may feel rushed to finish their meal.

We observed a number of staff interactions in the unit for people with a learning disabilities and saw that they were not always a positive experience for people. For example, we saw one member of staff being firm about telling a person to finish their meal. They did not listen when the person told them they did not want to eat some of what was on their plate.

During the day we identified some instances of poor care and were concerned that some staff would not be able to recognise minor concerns as they were seen as every day practice at the home. The staff did not show they respected the people who lived at the home. We heard them speak sharply to people and staff referred to people as tasks or by describing their behaviour. For example, they referred to people who needed support to eat their meals as "Feeders" and people who had little or no interaction with others except at meal times as "The room people."

We found people were not always supported in a way which helped them to maintain their dignity. A relative said that their son had not been supported to look well cared for when they took him out one day.

We also saw one person who had left their bedroom after receiving personal care had their jumper tucked in and their continence product was showing. The care worker with them did not help them to maintain their dignity. Fortunately the registered manager was walking past them and helped the person to untuck their jumper and maintain their dignity.

We were in the room with one person when a care worker brought them a hot drink, they complained that it was not sweet enough. The care worker took a used desert spoon off a tray they had collected from another person's room and used the handle to stir the person's drink. This showed a lack of respect for the person.

This was a breach of regulation 10 Health and Social Care Act2008 (Regulated Activities) Regulations 2014 dignity and respect.

Relatives told us they were able to drop in for a visit at any time and were always made to feel welcome. However, they also told us that staff did not support people to arrange outings with their relatives.

Requires Improvement

Is the service responsive?

Our findings

We identified a breach in relation to how people were supported have personalised care which met their needs. Care plans did not contain information on how people could progress. For example, one person told us they were bored and that they would really like a job. They explained that in the past they had a job where they helped people and would like to do so again, but did not feel that there was any opportunity to do so. Another person's local authority assessment indicated they would like to live independently in the community. But there were no goals in place to help the person improve their skills to achieve this. A relative said that they were not aware of any forward plans for his son and that he would, "Be doing what he is doing now for the foreseeable future." This showed that people were not supported to develop their independence.

There was an activities coordinator in post for 24 hours a week. They worked with people in the learning disabilities unit. Activities for people in the dementia unit were provided by the care staff. At the time of our inspection the activities coordinator had not had any training in providing activities for people. However, this had been identified as an issue and appropriate training had been identified. At present the activities support provided did not allow people to develop or maintain hobbies and interests. Some people were aimlessly wandering the corridors or sitting in their rooms with nothing to do. At lunch time people told us they did not have any idea what they would do during the afternoon.

In addition, independent living skills activities had been set up for four people in the home from October 2015. There was a 5 week plan in place for people to learn about health eating skills. Activity notes showed no further directed activities had been identified to increase daily living skills. There were no specific outcomes that were being worked towards or any promotion of progression for individuals. Everything was done as a shared activity with two people to one staff member. This meant people were not always supported to undertake the activity they would like. This shows no regard for individual choice and did not promote development of skills or interests.

This was a breach of regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 person-centred care.

The registered manager said and records confirmed that each person's care plan was regularly reviewed. This was done to make sure that they accurately reflected people's changing needs and that staff had the information they needed to care for people. However, while care staff ensured people's needs were met this was not done in a personalised way to fulfil people's individual requirements.

The care provided for people in the dementia unit was more personalised as there were only four people living in the unit. A relative of a person living in the dementia unit said, "[Name] is so well cared for here. The care is second to none."

Care plans contained information on how care should be personalised to the individual. Care plans also contained information on how people communicated when they were unable to directly tell staff how they were feeling. Staff were aware of people's communication skills and responded appropriately. For example, one person indicated they were finding the noise in the dining room distressing and staff removed them from the area for a while.

However, Care plans were not written in a user-friendly way. This meant that people may be unable to read and comment on their individual care plans. This reduced people's ability to share with staff how well the care was meeting their need and wishes.

The provider had a complaints policy in place. However, the registered manager told us they had not received any formal complaints in the last 12 months. The registered manager explained people were encouraged to raise concerns at any time and were able to show they had taken action when a concern had been raised. For example, one family had asked for a communication book to be completed and this was now in place. Staff told us they would support people to raise a concern if they were not happy with the care they received.

Inadequate

Is the service well-led?

Our findings

We identified a breach in the way the registered manager failed to identify poor care and take appropriate action. Staff told us the manager was approachable and they were able to raise concerns about the care people received as well as raise concerns about colleagues if they felt the care they gave people did not meet standards. Records showed the provider had regular staff meetings. This meant staff had the opportunity to raise concerns and discuss issues with the registered manager and colleagues.

The registered manager did not manage incidents appropriately. During our inspection we identified an incident where a member of staff had raised a significant concern about a colleague. This had been filed in a person's care plan. However, when we discussed this with the manager they were unaware that the incident had happened. They told us this was because they were on leave at the time of the incident. There were no systems in place to ensure all incidents reported were investigated and appropriate action taken. This meant the provider could not be confident incidents had been dealt with appropriately.

The registered manager told us and records showed that people living at the home, their families and health and social care professionals were asked for their views on the standard of care provided. We saw the survey results had been analysed and showed that people were not always happy with the level of activities provided. We saw that the provider had asked the registered manager to evaluate the results. However at the time of our visit there was no action plan to show how the provider or registered manager was going to improve care.

The registered manager also had a number of audits they completed to monitor the quality of service people received. For example, we saw audits were in place for monitoring medicines and for infection control. However, we identified a number of concerns which had not been identified by these audits. For example, in the dementia unit the clean towels in the bathroom were stored on top of the clinical waste bin. Staff told us this was normal practice as there was nowhere else to store the clean towels.

We also saw that the registered manager and the provider had not identified the concerns we had found in relation to people not having appropriate risk assessments, the culture in the home and how staff spoke with people, and the staffing levels to support people.

The provider is required by law to notify us when people are identified as being at risk of harm. During our visit we identified two incidents where people were at risk of being harmed. We asked the registered manager and administrator to ensure these concerns were raised with the local safeguarding team and that appropriate notifications were submitted to us. Following our inspection no notifications were received.

This was a breach of regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 good governance.

Staff told us the manager was approachable and they were able to raise concerns about the care people received as well as raise concerns about colleagues if they felt the care they gave people did not meet standards. Records showed the provider had regular staff meetings. This meant staff had the opportunity to raise concerns and discuss issues with the registered manager and colleagues.

The registered manager told us that they did not have resident's meetings for people as they had not worked. Instead they spent time talking to people in small groups about the care they received. However, there were no records to show what actions had been identified at these group meetings.

The provider regularly visited the home and audited the quality of the service provided, A report of action needed is sent to the manager following each visit. We could see from the last inspection that actions had been taken. For example they identified that a new activities coordinator had been needed and one was now employed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not have an effective system to assess monitor and improve the quality and safety of services provided or to identify, assess and manage risks to the health, welfare and safety of people using the service. Regulation 17 (1) (2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: People were not protected from abuse or improper treatment as systems and processes had to been established to identify abuse or to investigate abuse. Regulation 13 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: People were not treated with respect. The provider did not support their autonomy, independence and involvement in the community. Regulation 10 (1) (2)(b)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: There were not sufficient numbers of suitably qualified, competent, skilled and experienced staff. Staff did not receive appropriate support and training to enable them to carry out their duties. Regulation 18 (1) (2)(a)
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: The provider did not ensure the care and treatment people received was appropriate, met their needs and reflected their preferences. . Regulation 9 (1) (a)(b)(c)