Creating Lifestyles Surbiton Limited

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Inspection report

75-77 Effingham Road
Long Ditton
Surrey
KT6 5LA

Date of inspection visit:
03 June 2019

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17 July 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Creating Lifestyles Surbiton Limited provides personal care to people with learning disabilities who live in their own homes. The service consists of two shared houses where people hold their own tenancies but have staff on site for support at all times. At the time of our inspection, there were eight people living at the service and five people were receiving a regulated activity. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.
People's experience of using this service:
People did not always feel safe living at Creating Lifestyles Surbiton Limited. Some people had experienced aggression from others living at the home. These incidents had been recorded and reported but no action taken to prevent them happening again.

People's needs had not always been accurately assessed before they moved to the home. As a result, the home had admitted some people whose needs were not being met. Staff had not received all the training they needed to support people effectively. Care plans did not contain guidance for staff about how to provide the personalised support people needed.

Medicines were not always managed safely.
Bathrooms were not clean, which meant people were potentially at risk of infection.
Staff did not always treat people with respect or maintain people 's dignity when speaking to them.

Relatives told us communication from the service was poor. They said they were not always informed about incidents or accidents involving their family members. Relatives also told us they did not have opportunities to be involved in planning their family member's care.
Quality assurance systems were not effective in identifying concerns and the provider had not always notified CQC of events that they were required to do so by law.
People were able to make choices about what they ate and how they spent their time. There were enough staff on duty to support people to take part in activities. People were supported to maintain relationships with their families and friends.
People were supported to be independent, which they told us they valued. Staff felt valued and supported by the registered manager.
People were supported to have maximum choice and control of their lives and staff did support them in the least restrictive way possible and in their best interests; the policies and systems in the service did support this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last Inspection:
At the last inspection we gave the service a rating of good (published 30 December 2016).

Why we inspected:
This was a planned comprehensive inspection in line with our re-inspection programme.

We have identified breaches in relation to protecting people from abuse, safe management of medicines, infection control, treating people with dignity and respect, assessment of needs, notification of incidents and good governance at this inspection.

We have also made recommendations around involving families in people's care and ensuring people have healthcare appointments correctly recorded.

Please see the action we have told the provider to take at the end of this report.

Follow up:
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our Well-Led findings below.	**Requires Improvement**

Creating Lifestyles Surbiton Limited

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We planned this inspection to check whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team:
The inspection team consisted of two inspectors.

Service and service type:
This service provides care and support to people living in a 'supported living' setting, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
We gave the service 48 hours' notice of the inspection site visit because the service is small and we needed to be sure that the registered manager would be available to support the inspection. The inspection took place on 03 June 2019.

What we did before the inspection:
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us with key information about their service, what they do well, and

improvements they plan to make. This information helps support our inspections. We sought feedback from the local authority who work with the service.

During the inspection:
We spoke with three people who live at the service, five members of staff including the registered manager, the quality assurance manager and three care workers. We reviewed a range of records, including three people's care records and medication records. We looked at three staff files in relation to recruitment and staff supervision. We reviewed records relating to the management of the service, including policies and procedures.

After the inspection:
We spoke with one relative and we looked at training data and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations had not been met.

Systems and processes to safeguard people from the risk of abuse

- The provider had not ensured that people who lived at the home were safe from the risk of abuse. The registered manager told us there had been tension between some people which had led to arguments and incidents of assault.
- People told us the incidents meant they did not always feel safe at the home. One person said, "I feel in danger." The person told us they had been affected by aggressive behaviour and that not enough had been done to keep them safe. A relative said, "I don't feel like [my relative] is safe, there is an issue around risk assessments. When the first incident happened, what was put in place to stop it happening again?"
- These incidents had been appropriately reported but had insufficient action had been taken to protect people from the risk of harm.
- Care plans did not contain guidance for staff about how to support people who displayed behaviours that challenged the service. Staff had not received the training they needed to support people with aggressive behaviours.

The failure to protect service users from the risk of abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

Using medicines safely

- Staff had not always kept accurate records of people's medicines. Medicines had not been counted or signed into the service when they were delivered. As a result, one person had a five-month supply of one of their medicines in stock although this was not recorded.
- Protocols for people's PRN ('as and when required') medicines were not always fully recorded. For example one person had a PRN protocol for diazepam which stated how it should be given but no guidance on when it should be given.
- Medication administration records (MARs) were not always completed in line with relevant national guidance. Hand-written entries on the MARs were not signed by two staff members to check they had been correctly written. One person's MARs had a gap for that morning's administration. This meant the provider could not be sure that people were getting their medications safely.

Preventing and controlling infection

- The home was not clean, which meant people were potentially at risk of infection. Bathrooms had mildew around the shower cubicles, limescale on the shower curtains and a build-up of dirt on the paintwork. Both houses were not kept in a clean and tidy state and would require some further attention to bring them up to a good standard on cleanliness.

The failure to assess, prevent, detect and control the spread of infections and to ensure the proper and safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

● Staff were provided with appropriate personal protective equipment such as aprons and gloves. Staff were observed using this equipment when delivering personal care.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Any accidents people had were recorded and action taken to reduce the risk of similar incidents happening again. One person had several falls in their bedroom which staff observed occurred mainly in the evening. Staff had supported the person to implement a plan to reduce the risk of them falling.
● The provider had a business continuity plan, which set out the action to be taken in the event of an emergency to ensure people continued to receive their care.
● A fire risk assessment was in place and weekly fire tests were carried out with no faults recorded.

Staffing and recruitment;
●There were enough staff deployed to meet people's needs. The registered manager told us, "I have a brilliant staff team who will join in when they're needed. I'm really lucky with the staff team I've got. They go out of their way to make things happen for people." A staff member told us, "We have enough staff. We can support people on activities and if they need assistance we give them a hand." We observed that people did not have to wait for care and staff were on hand should they need any support.
● Recruitment files evidenced staff had been recruited safely. Staff's files included a full employment history, references from previous employers and a Disclosure and Barring Service (DBS) check. This ensures that people are safe to work with vulnerable people.
● People were involved with the recruitment of new staff. People were asked if they wished to take part in the interview process or if they had any questions that they would like to be asked on their behalf.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations had not been met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were not always accurately assessed before they moved to the home, which meant staff did not have the skills or training required to meet their needs.
- Consideration had not been given to people's past histories or support needs or how they would form relationships with people already living at the home. Staff told us some of the tensions between people had occurred because their ages, personalities and behaviours were very different. One staff member said, "My job is to tell them to get on together but it's hard for them. Can you imagine an 80-year-old man living with someone like [this person]." This was about people moving into the home with challenging behaviours that had not been correctly assessed and their placement put other residents as risk of harm.
- The registered manager told us that alternative placements were being explored for two people who had recently moved into the home. The registered manager said, "[This person] and [this person] are moving on purely because we don't feel the staff team is experienced enough to keep both of them." The registered manager also told us, "[This person] needs lots of activities and attention. They have one to one hours and then when they don't have that things go a little pear shaped." As a result the person's behaviour got worse when they were not receiving their one to one support which put other residents at risk of harm.

The failure to ensure appropriate assessment of needs and preferences for care and treatment of the service user was a breach of Regulation 9 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

Staff support: induction, training, skills and experience;

- The provider had not ensured staff had the right training to meet people's needs. For example, autism, keeping safe and positive behaviour support training had not been delivered to staff. The registered managed provided us with a training matrix for staff. However, from talking to people and staff it was clear that the complex needs of people had not been considered in the training packages. This meant that people were not always supported to manage behaviours and people were not kept safe.
- Staff told us and records showed that staff were not receiving regular supervision. This meant that staff did not have the opportunity to discuss their performance and training needs or any concerns they had. We asked the registered manager and the provider about this who recognised that there was work to be done to ensure all supervisions and appraisals were completed.

The failure to ensure appropriate training for staff as is necessary to enable them to carry out the duties they are employed to perform was a breach of Regulation 18 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014

Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support;

● People were given a choice of what they would like to eat and drink and were supported to buy and prepare their own food. We saw one person make their own choices at lunchtime and go shopping with staff to buy the food they wanted.

● We observed a two-week food menu which was for evening meals. The menu set out food that was available to residents and staff told us that people could choose to have an alternative If they wished. Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support

● People were provided with access to healthy food options. We observed people being encouraged to prepare and eat vegetables and fruit as part of a varied diet.

● Referrals to healthcare professionals were not consistently recorded. Records showed that one person had seen a GP, chiropodist and physiotherapist with these appointments clearly documented. However, there was no record of having attended a dental appointment since December 2015 despite a missed appointment reminder and a letter referencing the state of [This Person's] teeth being in the care plan. The registered manager said person had attended but no record of the appointment had been made.

We recommend the provider consider current guidance to ensure that all people who access healthcare appointments have these, and any treatment provided is recorded.

Ensuring consent to care and treatment in line with law and guidance;
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 to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

• At the time of inspection no one using the service was the subject of a DoLS authorisation.

• Staff had a good understanding of the how to apply the principles of the MCA in their day-to-day work. One staff member told us, "People here are able to make their own choices about their care and support and what they would like to do," The registered manager told us, "Everyone here is free to come and go as they please and they have the capacity to make their own decisions."

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations had not been met.

Ensuring people are well treated and supported; respecting equality and diversity;
● People were not always supported in a dignified way. We observed a member of staff approach a person whilst they were still asleep and say, "Hi [name], do you want to get up and go to the toilet? One, two, three, there you go." The member of staff assisted the person to stand up although there was no indication that the person needed to use the toilet. The member of staff used paper towels to wipe the person's face and said, "Good boy" and. "Say thank you".
● We observed one person asleep in a chair with the television on whilst two staff members talked to one another and giggled in the same room. Despite the quality assurance manager speaking to one of the staff about their behaviour, it continued ten minutes later when the staff members started talking to one another about football. This showed a lack of respect for the person in their own home.

The failure to ensure service users were treated with dignity and respect was a breach of Regulation 10 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

● People were asked about their religious preferences when they moved into the home. Two people had an interest in the local church and were supported to attend whenever they wanted to go. People were also encouraged to talk about their sexuality and sexual preferences if they wished to do so.
● Staff made people feel they mattered by celebrating important events. The registered manager told us that people visited the pub together to celebrate birthdays.
● People were supported to maintain relationships with family and those important to them.

Supporting people to express their views and be involved in making decisions about their care;
● People and families were not consistently involved in planning their own care. One relative told us, "I have been involved in one or two reviews in five years. Unless [my relative] calls me I am not made aware of anything."

We recommend the provider involves people's families in reviews of their care and support needs.

● People did have the opportunity to make choices such as at meal times and whether they wanted to join in with the activities that were on offer.
● We saw people were offered choice in everyday situations such as where they would like to sit and how they wanted to plan their day. Care plans contained guidance for staff which promoted choice for people, for example, one person will choose what they want to wear each day.

Respecting and promoting people's privacy, dignity and independence;

● People were supported and encouraged to be independent where possible. One person told us, "The best thing about living at the service is that I'm independent, I can do things for myself and staff can help me if they need to." We observed this person choosing their own food, going shopping and cleaning up after themselves. A staff member told us, "I enjoy watching these people succeed and accomplish things on their own, you can see the satisfaction it brings to them. We support them when they need it or ask but it's really nice to see them being independent."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations had not been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control;
● Peoples' care plans did not always reflect their needs. One person who was waking at night and sleeping during the day did not have any information on how to support them with this.
● The registered manager said one person was living with dementia but later stated that there had been no official diagnosis as this had not been possible due to their learning disability. There was no information on file to say if this person had dementia or not and how this may impact their care.
● There were few details recorded about people's life histories or their likes and dislikes, which meant staff did not have the information they needed to personalise people's support.
● Staff did not record sufficient detail in people's care notes. For example, staff had recorded in one person's daily notes that the person had interacted with staff and other residents. There was no detail about what type of interactions took place or the support that had been provided.

The failure to design care to meet people's individual needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

● People had input into the planning of activities and a choice over which activities they took part in. These included music, movies, local walks and board games. Some people were supported to go shopping.
● People were supported to access personalised activities. The registered manager told us one person had been supported to compete in an X-Factor style event, which they won, and to go to the gym. Participation in these activities had resulted in the person having an increase in confidence.

End of life care and support;
● Care plans did not record people's wishes as to how they wanted to be supported towards the end of their lives. The registered manager told us that people would be given the opportunity to discuss their wishes about their end-of-life care and that these would be recorded in their care plans.

Improving care quality in response to complaints or concerns:
● The service had a complaints procedure which set out how complaints would be managed. Records showed that one person who had made a complaint about the service did not receive a response for almost four months. The registered manager had conducted a full investigation into the complaint and also issued an apology to explain why there had been a delay in responding.
● People and relatives told us they would feel comfortable in raising any concerns. A relative said, "Any problems, I'd take them straight to [the registered manager]." One person told us, "I would always tell the staff if I had a complaint. I'm happy to do that. They would tell me not to worry and sort it out for me."

Meeting people's communication needs:

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Information about the service was made available to people in ways they could understand. For example, staff read documents to people if needed and information was available in 'easy read' format.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility;

- Audit systems were not effective in identifying concerns. The registered manager and the quality assurance manager carried out checks to monitor the performance of the service and staff. These included checks on falls, medication, health and safety and care plans. However, these checks had not identified the concerns that we found during this inspection including risk assessments, medicines, the lack of cleanliness and care planning.
- Relatives told us there was a lack of communication from the service. One relative said, "I don't get any feedback and I don't receive any updates on [my relative's] care and support." The relative told us, "[My relative] came to visit but his medication had been changed but I was not informed of this and this meant that they were unable to continue the visit."
- Relatives told us they were not updated about incidents or accidents involving their family members. One relative said, [My relative] had to attend hospital due to an incident which gave them back pain. I was not updated of what medical advice had been given or any diagnosis, I was only made aware when [my relative] called me."

The failure to assess, monitor and improve the quality of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

- Notifications of safeguarding concerns had not been reported to the Care Quality Commission. The provider had not always notified us of events that they were required to do so by law. This meant that the Commission had been unable to monitor the concerns and consider any follow up action that may have been required.

The failure to notify was a breach of Regulation 18, Notification of other incidents, Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;

- Staff told us the registered manager had begun to improve the service. One staff member said, "[Registered manager] has done her best to develop this service and help staff to support people. Things have got better. I think she could do with some more support to share out the work."
- The registered manager told us, "[Person] is my direct line manager and he is in regular contact with me

by phone. He is also under pressure and he has had to cancel a couple of 1-2-1 sessions but I can contact him anytime I need to talk things through."

● Staff told us they felt valued. A staff member said, "If you had a problem you would feel comfortable going into the office and speaking to them." Another staff member told us, "[Registered manager] is good because she has listened to me and my personal circumstances and she supports me fully in what I need." A third staff member said, "I like it here, I get along with the clients and the manager. The team work is good."

● People's views were actively sought during meetings and through surveys. Staff, people and relatives were sent a survey in September 2018. One person commented, "I get along very well with staff and other residents except for [this person]." Another person commented, "I am happy with everything except the house curtains need changing." Following this survey new curtains were installed.

Continuous learning and improving care: Working in partnership with others;

● The registered manager had a clear vision in place to make things more person-centred for people. For example, the registered manager was aiming to obtain input from a psychiatrist for one's person's mental health needs. The registered manager was talking to another person about moving from a first floor room to a ground floor room due to their deteriorating health and risk of falls.

● The service worked closely with other organisations. The registered manager said that they worked closely with other healthcare services such as the local GP's, hospital, district nurses, local council and community groups such as the adult learning centre, YMCA and British legion groups. This enables people to maintain relationships in the community and increases their confidence and independence.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure appropriate assessment of needs and preferences for care and treatment of the service users. The provider failed to design care to meet people's individual needs

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure service users were treated with dignity and respect.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess, prevent, detect and control the spread of infections and to ensure the proper and safe management of medicines

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to protect service users from the risk of abuse.

Regulated activity	Regulation

Personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider failed to ensure appropriate training for staff as is necessary to enable them to carry out the duties they are employed to perform.