Lothlorien Community Limited

The Willows

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

We carried out an unannounced comprehensive inspection of this service on 24 February and 2 March 2015. After that inspection we received concerns in relation to staffing in the service, staff knowledge and skills, staff morale and the safety of people living there. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Willows on our website at www.cqc.org.uk

The Willows is an all-male household and provides accommodation and personal care for up to six adults with a learning disability and behaviours that can challenge. At this inspection there were five people living in the service. There is a communal lounge/dining room, a small lounge and a kitchen with seating on the ground floor. There is a garden with a paved area at the back of the home.

The home is run by a registered manager who was absent on planned leave for one year. In the absence of the registered manager, an interim manager had been appointed who was present at the inspection. 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.

Concerns had been raised that there were not always enough staff on duty to support people safely and that some staff may not have the necessary skills.

Some people told us that they liked living in the service, but were made unhappy or upset when they witnessed or were involved in incidents involving other people they lived with.

Since the last inspection the provider had taken steps to recruit new staff but there were still vacancies. Some

Summary of findings

people now needed more support but staffing levels had not been adjusted to reflect this. Care staff told us they felt stressed by the present situation and did not feel that staffing levels were enough to keep people safe, particularly when everyone was at home and incidents were more likely to occur. Staff lacked confidence in working alone with some people particularly when out with them in the community.

Not all staff had received safeguarding training to recognise and act on abuse. In conversation they lacked awareness that enabled them to distinguish everyday incidents from those that would meet the criteria for a safeguarding alert, there was a risk therefore of some safeguarding incidents being under reported. Staff understood how to report and record other incidents appropriately and this information helped inform whether changes in support were needed.

There were weaknesses in some operational record keeping which did not always provide a clear picture that procedures had been followed. For example, some staff had received training in administration of medicines but their training documentation failed to reflect this or that competencies had been assessed.

Risks to people's safety were assessed and measures were put in place to minimise the level of risk identified, staff told us and we saw that these were not always adhered to and this did place people and staff at risk.

The induction of new staff was not always recorded, therefore the interim manager was unable to assure either themselves or the provider of what the staff concerned had learned, read or achieved competency in during the period they had been in post. Staff had been put forward for essential training, but the provider had not been proactive in ensuring essential training was prioritised for staff dealing with people with complex needs; this could lead to people not receiving appropriate care and staff not feeling sufficiently informed or confident to deliver an appropriate level of support.

Staff told us their morale was low, some staff felt less well treated than others, and there was not a cohesive sense of team. Staff said they received supervision where they were able to express their views, but did not always feel supported that the issues they raised were acted upon.

Regular checks of the premises were made to ensure people lived in a safe environment and equipment was serviced and in working order.

People attended monthly 'your voice' meetings where they exchanged news and experiences with people from other services, they were given support if they had concerns they wanted to raise. A system to seek feedback from relatives and other stakeholders was not in place to inform or influence service development, but the interim manager told us they maintained active and good links with relatives, but this was not evidenced clearly within records.

Staff engaged well with people, except when incident occurred, and they supported them to lead busy active lives and made good use of the community. People were supported to develop and maintain relationships with people outside of the service.

There were continued breaches and three further breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what actions we have asked the provider to take at the end of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement 

The service was not always safe.

There were not always sufficient staff available that had the necessary skills and knowledge to support people safely.

Staff did not feel confident in managing people's behaviour and some agreed risk measures were not always adhered to. Staff understood safeguarding but lacked awareness of how to distinguish some incidents as safeguarding. Staff did not value the whistleblowing process.

There was a programme of regular health and safety checks and maintenance to ensure people lived in a safe environment.

Is the service well-led?

Requires improvement 

The service was not consistently well led.

Actions to meet previous legal requirements were not fully met within timescales given. Recording was poor in a number of areas. Staff did not feel that issues they raised were acted upon. Staff morale was low.

A system of quality auditing was in place but was not fully effective and some shortfalls were overlooked.

The views of relatives and stakeholders were not sought although people using the service were provided with opportunities to express their views.

The Willows

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 was undertaken on 13 August 2015 and was unannounced. The inspection was carried out by one inspector in response to concerns received by the Care Quality Commission.

Prior to the inspection we looked at previous inspection reports and any notifications, concerns and information received about the service since the last inspection.

We undertook a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not or chose not to talk with us. We spoke with three other people who lived there; we observed staff interactions and support with daily activities and communicating with people during our inspection. We spoke to the interim manager, two care staff, a maintenance person and the regional manager who was present during part of the inspection. We saw the communal areas of the service. We spoke with staff about the care needs of people living in the service and looked at care plans for two of them where changes had occurred, we were able to speak with one of these people, and also to observe staff support of them.

During this inspection we viewed a number of records including three staff recruitment records, staff training programme, records of staff supervision, staff rota, risk assessments, people's activity planners and quality assurance information.

Requires improvement

Is the service safe?

Our findings

People we spoke with said they liked living in the service and were happy there, they spoke about the things staff supported them to do outside in the community. Two people said that when incidents happened in the service between people this made them feel 'unhappy' and 'upset'.

At the last inspection we found that there were not always enough staff available to meet the assessed needs of the people living there. Staffing levels were calculated based on the assessed needs of people and how much support they would need and how many staff would be required to provide this. Since the last inspection one person had moved on from the service. Of the five people remaining who needed support, one required individual support during the day and one required individual support during the day and at night time. Therefore, three members of staff were required during the day and one waking and one sleeping-in staff at night time. The service was still carrying vacant care posts and these hours were being covered by existing staff from this and another of the provider's home nearby. The action plan submitted to CQC by the provider told us that a review of staffing hours would be undertaken and that a programme of recruitment would be undertaken to fill vacancies and avoid the need for staff to cover extra hours. This would be completed by 30 June 2015.

On arriving at the service we found there were just two staff on duty to support all five people, two of whom were meant to have one to one staffing. A staff member told us that they had been on duty between 6:30 am and 8 am on their own, before a second staff member who was new joined them. They said that they felt pressured by the need to support everyone; this had been made worse by an escalation in one person's negative behaviours. This had caused an increase in the number of incidents with other people in the house, and which staff said were now a daily occurrence. Staff added that they felt under pressure to be vigilant of the possible onset of incidents and also to give the other people in the house the attention they needed.

People were not given the support they needed at the time they needed it because there were not enough staff on duty to provide this. When we arrived one person was walking around trying to gain staff attention still dressed in their pyjamas, he was constantly told they would speak to him presently. Two other people were in the kitchen waiting for breakfast. A maintenance person was present and was drying up dishes which he felt would help staff; he was also supporting a service user with problems he had with his lap top. A fourth person was in the lounge, they had vomited over their clothing and on the floor. Staff had not noticed this until they came to answer the door to us. The staff member looked flustered and immediately attended to the person and gave them gentle affirmation that everything was alright and they would soon sort things out for them. A fifth person was sitting quietly in a corner of the TV room on a bean bag cushion, unnoticed by staff. Staff said the person preferred to sit here rather than in other rooms. The person was undemanding but we observed them to be in a positive mood throughout the inspection. However, on those occasions when people and staff walked through the TV room we saw that no one visibly interacted with them. However, when the person moved from the floor to the settee and came into staff vision, a staff member was seen to acknowledge them warmly when walking past. There was a risk that with staff being so busy this person could become isolated and their need for positive interactions with staff or others could be overlooked.

The rota showed that the interim manager was recorded on the rota as the third person on duty; but arrived late on shift at 9:15 am. Staff reported that although the manager did help with taking people to activities and evening clubs, when on shift in the house much of her time was spent on office related duties, they felt this was not helping to ensure there were enough staff on duty to support people, particularly as two people required individual support during the day.

The provider had recruited new staff but there were delays in processing their documentation and they were unable to commence work until all their checks had been cleared. Staff recruited after the last inspection had also since left so the service was continuing to deal with staff shortages. Existing staff from this and the sister home (who knew people's needs) provided cover by working overtime. There was a risk that staff working long hours would not be as effective, and a staff member said they had witnessed irritability towards some service users from some staff when responding to people.

There was a failure to ensure that people were supported by sufficient numbers of staff who were available at all

Requires improvement

Is the service safe?

times to keep people safe and meet their needs. This is a continued breach of Regulation 18 (1) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Where specific risks were identified for people from their environment or from participating in the community, these were individually assessed and measures were implemented to reduce the potential risk of their experiencing harm. For people who were considered to be at risk from harming others or themselves, the risk was potentially lowered by providing them with one to one support. We looked at the risk assessment for a person who should not leave the service unaccompanied and saw that this had recently been updated, and additional measures had been introduced to minimise this risk. These included an alarm on the person's door, locks on the window and regular monitoring by staff. We saw that staff were regularly checking to make sure this person was safe within the service. However, discussion with staff found that on at least one recent occasion, the alarm alerting staff to the person leaving their room at night had been found turned off. It was thought this had been done so that others in the house were not disturbed by the alarm. This defeated the purpose of the alarm and posed a risk to the person's safety as safeguarding measures were not implemented or adhered to consistently. This incident had not been reported to the interim manager by staff, but we ensured they were made aware of it and they said they would take urgent action to remind staff that the current measures in place must be maintained at all times.

In the dining room we witnessed an example of one of the daily incidents that occur between two people in particular. The staff present were not trained to respond and intervene appropriately to such incidents and awaited the arrival of the interim manager. By which time the incident had escalated and one person experienced a physical assault by another. Risks were not being appropriately managed because staff did not take appropriate action to de-escalate developing situations in keeping with people's specific risk assessments. The interim manager and senior managers were aware of the impact the change in the persons behaviour was having on other people and staff, and were in consultation with health and social care professionals, but were still awaiting appointments for a reassessment of the persons health needs. In the meantime, no additional resources were available to help reduce the risks of further incidents or harm occurring.

There was a failure to protect people from abuse and improper treatment and this is a breach of Regulation 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with staff about protecting people from abuse and they showed that they understood their responsibilities for reporting concerns and abuse. However, when we discussed the specific incident we had witnessed with them, they showed a lack of awareness as to whether this would be considered a safeguarding matter; they felt this decision would be taken by the interim manager and not them. There was a risk that in the absence of the interim manager staff may not recognise that some incidents constituted abuse. People could therefore be left at risk because these incidents may not be reported and acted upon appropriately. Staff showed a lack of confidence in the whistleblowing process and told us about two incidents that they had not shared with the interim manager. One staff member said that issues they had previously reported had not been acted upon and they saw little value in using the whistleblowing process to report issues in future. We made the interim manager aware of both issues raised with us and she confirmed she would take action to look into these.

There was a failure to ensure that people were protected because staff had a clear understanding of what incidents should be reported under safeguarding, and had confidence that matters they reported under the whistleblowing process would be acted upon. This is a breach of Regulation 13 (1) (2) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We looked at recruitment processes because since the last inspection new staff had been recruited, but were still to commence work. Records of new staff contained all the information required by the legislation with evidence that each applicant completed an application form and attended for interview. Information was gathered about their previous conduct in employment, and their work histories, the reasons for gaps in employment histories were clarified with them at interview, personal identification and criminal record checks were made to ensure they were suitable for the role. This showed that the recruitment process was robust and helped to ensure that people were only supported by staff that had been assessed as suitable.

Requires improvement

Is the service well-led?

Our findings

At the last inspection we identified that the provider had not been proactive in identifying shortfalls within the service and then making the necessary changes to address these. We had noted that despite the provider stating on their website that specialist advisors were available in regard to Prader Willi Syndrome, Autism and people with challenging behaviour, training for staff in some of these areas such as Autism and support of people with their behaviours was only organised following that inspection. We also noted that there had been ongoing changes to the staff team and this had impacted on one of the people living there in particular.

At this inspection the previous shortfalls we had identified at the previous inspection in February and March 2015 had not been addressed within the timescales given to us by the provider in the action plans they sent to us. Staff told us and records showed that the staff team was still unsettled with a number of further staff changes having taken place. The lack of stability within the staff team had made it difficult for the interim manager to address morale and team building issues. There was a lack of enough staff with the right skills and knowledge; this made it difficult for existing staff to absorb and cope well with the changes happening in some people's individual support needs. There was a risk that they could not provide meaningful support to the other people that lived in the service who also had complex needs but demanded less staff time. For example the deterioration of one person's behaviour was impacting significantly on staff that now needed to be additionally vigilant in the house, and deal with incidents between service users on a daily basis, other service users were at risk of being assaulted or of defending themselves aggressively. The loss of specific support staff for another person that required other staff to fill the gaps was a source of concern to staff; they felt unprepared for this and lacked confidence in working with this person. There was a risk that this could impact on the quality of experiences and activities this person was supported with in the community.

All staff had completed Prader-Willi syndrome training and the majority had completed Autism awareness training. People in the service, however had specific needs that could be challenging, it was essential that the staff working with them had the right knowledge, skills and confidence to support them safely and appropriately. This inspection highlighted that staff were still waiting for this training to be delivered; no prioritisation had been given to this, despite the provider offering assurances after the previous inspection that this training was being arranged. New staff were joining the team and they and existing experienced staff would not have the necessary training to support people with complex behaviour safely or consistently.

One of the two staff we met had only been in post six weeks and was still on induction. They told us that they had completed some on line training but when we asked what courses were completed, none of those completed to date offered the essential skills they needed to carry out their support of people safely. However, they told us that they had spent time reading peoples individual care plans and in shadowing more experienced staff when they supported people. They said they felt able to offer appropriate support to some people in line with their care plans, but were not confident in working with those people whose behaviour could be challenging, because they had not received training to manage their behaviour effectively or confidently.

Staff said they had to complete their required on line training whilst on shift. They were not allocated time for this development by the provider. They said this made it difficult to support people effectively whilst they were occupied in completing the training which was undertaken on a computer in the office. Some experienced staff had not completed training which would give them confidence in supporting people with negative behaviour.

There was a risk that without specialist training staff did not have the skills and knowledge to fulfil their role appropriately and people could receive inappropriate or inconsistent support. This is a breach of Regulation 18 (2) (a) Of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Actions taken to address shortfalls from the previous inspection were slow to be implemented and remained unmet within the given timescales. For example, the provider had told us in their action plan that they would have all the required staff in post by 30 June 2015. More new staff had been recruited but delays in processing their required checks left them unable to commence work in the service. There were not enough staff to meet the changing needs of people who lived there, some of whom now required more support. There was recognition of the need for extra support from the provider because they had

approached the funding authorities for additional funding, but in the interim, steps had not been taken to ensure people were supported at the levels they required until funding issues were resolved.

The interim manager was given regular support from the regional manager who visited regularly and was a familiar figure to people and staff in the service. However, the Interim management arrangements had not ensured that staff felt supported or involved in decisions about changes to the service. The interim manager in conjunction with the regional manager had discussed changes they wanted to make to the service to take it forward, and an action plan was in place for this. However, staff said they had not been kept informed of the proposed changes or the rationale behind some of those already implemented, for example changes to the start and end times of shifts and a reduction in some staff hours. The interim manager acknowledged that some of these changes had been made with the intention of improving things for staff but that these had not been consulted widely with them.

A staff member told us that although the manager was approachable and listened to what they had to say both in supervisions and in staff meetings they did not feel confident that their concerns were acted upon. For example, a staff member told us they had reported a matter of concern about another person's practice around recording medicines but felt this had not been dealt with. They lacked confidence in the whistleblowing process, and felt that other staff were treated differently to them, they lacked confidence in the whistleblowing process and that their concerns were acted upon.. We spoke to the interim manager who recalled the incident and made clear they thought they had dealt appropriately with the matter, but when asked could not provide any records of the incident or the action taken to provide assurance this had been dealt with satisfactorily.

We received concerns that staff morale was low and a staff member confirmed this. Staff said that communication was not as good as it could be, and there was a lack of clarity for a new staff member about whether staff used a communication book or not to pass on information. Staff meetings were held but the regional manager and manager recognised there were a range of issues that staff were unhappy about that needed to be aired and tackled. They said they had requested support from their Human Resources department. This was to provide a face to face meeting between staff and a Human Resources representative to talk about the issues getting in the way of staff feeling part of a team, and they agreed to push for such a meeting to be held soon.

The provider sent us an action plan following the last inspection to state that shortfalls to the quality assurance processes that informed the provider about shortfalls would be addressed by 30 May 2015. A range of audits were undertaken by the manager with a regular service review by the regional manager. However, the effectiveness of the audit processes in place had not improved and continued to fail to pick up shortfalls highlighted by inspection. For example, staff induction and training records were incomplete. Resources to address issues were slow to be provided for example, a settee in the television room was without cushions, we were told this was waiting to be taken to the dump, but a replacement settee had not been provided and the old settee placed outside for dumping. There was no system in place to seek and collate feedback from relatives or other stakeholders about service delivery, although the manager reported they maintained good links with all family members.

There was a failure by the provider to ensure there was an effective system in place to identify and take action to address shortfalls in the provision of the service, or to seek the views of persons

acting on behalf of people receiving the service. This is a continued breach of Regulation 17 (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they met monthly at different houses operated by the provider to give them an opportunity to meet and chat with people from other services. People said they spoke about things they liked doing, and also about things they did not like or were unhappy with, they said they told staff who tried to help them sort things out, one person said they wanted to return to day care instead of doing a range of other activities instead. Staff felt that offering the person a wider range of experiences was better for them but accepted that this should be the person's decision. The regional manager felt the 'your voice' forum provided people not with just an opportunity to express their views but to also take some control of how to resolve the issues, and they would be asked to contribute for their views around this.

Requires improvement

Is the service well-led?

The interim manager communicated well with people in the service according to their individual needs and this showed that she knew people well and they felt comfortable approaching her with matters they wanted to discuss. The regional manager was a familiar figure to people in the service who were seen to be confident in approaching him with things they wanted to talk to him about.

The service met the legal requirement to display its inspection rating within the service and whilst this was also recorded on the service website this was not prominently displayed as required. We have brought this to the attention of the regional manager to review these arrangements.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment There was a failure to protect people from abuse and improper treatment by people they lived with 13 (1) (2) There was a failure to ensure that staff had a clear understanding if incident reporting under safeguarding and that they had confidence in the effectiveness of the whistleblowing process 13 (1-3)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have an effective system in place to identify and take action to address shortfalls in the provision of the service.17 (2) (a) The provider did not have an effective system for seeking the views of persons acting on the behalf of people. 17 (2) (e)

The enforcement action we took:
We have issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People were not supported by sufficient numbers of staff being available at all times to keep people safe and meet their needs. Regulation 18 (1) Staff had not received the specialist training needed to give them the skills and knowledge to support people appropriately. Accurate records of staff induction and training were not maintained to ensure all relevant training had been completed. Regulation 18 (2)(a)

The enforcement action we took:
We have issued a warning notice