Care Quality Commission

Turning Point
The Crescent
Inspection report

22 The Crescent
Doxey
Stafford
ST16 1ED
Tel: 01785 243712
Website: www.example.com

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Ratings

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

Overall summary

This inspection took place on the 8 July and was unannounced. This was 'The Crescents' first inspection since being registered in October 2014.

The Crescent is a supported living facility and offers personal care to up to eight people with a learning disability in their own homes. There were eight people using the service at the time of the inspection.

The service is required to have a registered manager. The manager had been in post for three months and had not yet registered with us. 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.

The systems the provider had in place were not always adhered to, to ensure that care being delivered to people was safe and of good quality. People were not always

Summary of findings

protected from the risk of abuse. Risk of further abuse was not reduced following incidents. Relevant people were not always kept informed of serious incidents that affected their relative.

People were supported to take reasonable risks to increase their independence. Risk assessments supported staff to keep people safe whilst promoting their independence.

There were sufficient numbers of staff to care for people safely. Staff had been trained and understood their role.

People's medicines were stored and managed safely. The provider had implemented a new system to protect people from medication errors.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLs) and to report on what we find.

The manager told us that there had been several DoLS referrals made to the local authority to ensure that people were not being unlawfully restricted of their liberty.

People's health care needs were met. People received regular health support from external agencies. Staff supported people to attend health care appointments.

People were supported to maintain a healthy diet. When people had specific nutritional requirements staff had been trained to provide their food and drinks in a way that supported them.

Records, observations and discussions with staff demonstrated that people using the service were at the centre of the care being delivered. Regular reviews took place to ensure that when people's preferences had changed this was identified and acted upon.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe. People were not always protected from the risk of abuse. When suspected abuse had taken place the risk of it occurring again had not been reduced.

People were supported to take reasonable risks to increase their independence by sufficient staff to keep them safe. People's medicines were managed safely.

Requires Improvement

Is the service effective?

The service was not consistently effective. Some incidents of restraint were not recorded, as required.

The provider followed the principles of the MCA and DoLS to ensure that people were supported to make decisions in their best interests. People were supported to maintain a healthy diet. People were supported to attend appointments to support their mental, physical and emotional wellbeing.

Requires Improvement

Is the service caring?

The service was not consistently caring. People's preferences were not always respected. People were not always supported to maintain the relationships which were important to them.

People's privacy was maintained.

Requires Improvement

Is the service responsive?

The service was responsive. People were supported to be involved in the community and enjoyed a range of hobbies and activities of their choice. People's care needs were regularly reviewed. There was a complaints procedure and relatives knew who how to use it.

Good

Is the service well-led?

The service was not consistently well led. There was no registered manager in post. Incidents of suspected abuse had not been fully investigated internally. Systems were in monitoring the quality of the service were not effective.

Requires Improvement

The Crescent

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 8 July 2015 and was unannounced.

The inspection team consisted of two inspectors.

During the inspection process we met with two people who used the service and two relatives. We spoke with three members of care staff, the team leader and the manager. We spoke with a social care and health professional.

We looked at four people's care records, staff recruitment records, staffing rosters and the quality monitoring systems the provider had in place. These records helped us understand how the provider responded and acted on issues related to the care and welfare of people, and monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

People who used the service were not always protected from abuse or the risk of abuse. We had been made aware of a serious incident between two people who used the service, which had resulted in one person being seriously assaulted. This had been referred to the local authority for investigation. However nothing had been done to minimise the risk of the incident happening again, the provider had not followed their own procedure to ensure that people were safe. We were told there had been an updated risk assessment put in place however the manager and team leader were unable to locate it. Staff we spoke to could not tell us how to minimise the risk of the incident happening again. This meant that people were at risk of abuse due to people's individual risk assessments and care plans not being followed and the provider not internally investigating staff practise which had led to the abuse taking place.

These issues constitute a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The relatives we spoke with had differing opinions on whether their relative was safe at the service. One relative told us: "Staff know my relative well and know who they don't get on with, I'd like to think they were safe". However another relative told us they didn't feel their relative was safe because of a recent incident which was currently being investigated.

People were supported to take risks to increase their independence within their own home environment. One person wanted to be able to make a cup of tea, but could not hold the kettle. Staff had helped the person choose a tea making machine which meant that they were able to make their own tea without being at risk of scalding themselves. This person asked us: "Would you like a cup of tea? I can make you one". This demonstrated that the staff were encouraging this person to be independent whilst keeping them safe.

We saw that there were enough staff to meet people's needs. Each person was allocated a member of staff. There were additional staff available to provide one-to-one support when, for example, people wanted to go out into the community. When people's needs changed, staffing was increased to ensure sufficient staff support. Staff told us and records confirmed that staff were recruited using suitable recruitment procedures which included checks for their suitability to work with people.

People's medicines were stored and administered safely. Staff who administered medicines were trained and assessed as competent to do so. In response to medication errors a new medication system had been put in place to reduce risks in the future. Some people could not tell staff if they required medication for pain or anxiety. We saw that the guidance provided for staff for the administration of 'as and when required' (PRN) medicines were clear and concise. This meant that staff could recognise when people might be in pain or anxious. Staff we spoke to knew how people liked to have their medicines, for example one person liked their tablets put onto a spoon for ease and another person liked to have a jam tart with theirs as it made them more palatable. This meant that this person had their medicines in a way in which they preferred.

Requires Improvement

Is the service effective?

Our findings

Some people who used the service required support from staff when they became anxious and a risk to themselves and others. Staff were trained to support people during these times and individual risk assessments were in place for the use of physical intervention (restraint). However concise records were not kept of every incident where a person had been restrained to ensure that restraint was monitored and that it was proportionate and managed safely.

Some people who used the service required support from others in making decisions about their health, welfare and finances. The principles of the Mental Capacity Act 2005 (MCA) had been followed, which ensured that all the relevant people were involved in the process and the decision was deemed in the person's best interest. We saw that everyone had mental capacity assessments. The assessments identified which decisions a person would need support with. We saw that, in line with best practice, there had been times when decisions had been made for people in their best interests. Some people were being restricted of their liberty, we saw that these people had all been referred to the local authority for an assessment and were awaiting an outcome. In the meantime risk assessments were in place to ensure that the restrictions that were in place were the least restrictive and kept under review.

Staff we spoke with knew people well and told us that they had been trained to fulfil their role. Some people had specific health care needs such as diabetes, staff were able to tell us the signs and symptoms they would see if the person was becoming unwell and what the correct procedure to follow was. A relative told us: "The staff are competent, they get [Person's name] up to the hospital as soon as possible if there is a problem with their on going health issue".

People had a choice of what to eat and drink. One person had been shopping for their groceries and told us: "I'm having fish and chips today". This person invited us into their flat and showed us their fridge. We saw that this person had been supported by staff to buy healthy food that met their needs, such as low sugar jellies. One staff member told us: "People have what they want, we try and encourage healthy options, but they sometimes change their mind and choose something else". People with specific dietary needs were supported. Staff told us about a person who required a soft diet because of problems they experienced with swallowing. Staff were able to tell us how they had been trained to soften the person's food to the correct consistency. Another person needed to have their fluid intake monitored due to frequent infections. We saw that there were inconsistencies in the recording of this person's fluid intake and that the total amount was not totalled. This meant that they could not be sure that the person was drinking the recommended daily amount to maintain their health.

People received health care support when they required it. We saw one person attended the Dr's with a member of staff on the day of our inspection. We saw that people were supported to see their community nurse, consultant psychiatrist and attend hospital appointments. Staff and the manager sought support, in a timely manner, from health care professionals, when there was a change in people's health needs.

Requires Improvement

Is the service caring?

Our findings

A person who used the service told us: "The staff look after me". However people's preferences in relation to staff were not always respected. We were told that one person who used the service did not like a certain member of staff and this was known to all staff and the manager. We were informed that this staff member on occasions was allocated to work with the person despite management and staff knowing and being reminded that the person did not like them. This meant that this person's preferences were not being respected.

We were told that people's relatives and friends could visit at any time. However a relative was asked not to visit on the day of the inspection as it may unsettle the person. Although the relative agreed to not visit it was not clear why they could not and it was not in the person's care plan. Some people had an advocate to support them and to help them be listened to. Other people had families and friends. We were informed by one relative that they had not been told about a serious incident that involved their relative until sometime after the event. This had left them distraught and feeling disrespected. There was nothing in the person's care plan to support the decision not to inform the relative. The manager agreed that this person should have been informed. This meant that this person's representative was not being fully involved and respected in matters that affected their relative.

People's privacy was recognised and promoted. We observed that staff knocked on doors or rang door bells before going into people's flats. The manager told us that they were working hard in instilling the culture of respect into the staff as some staff had found the transition from working in residential services to supported living difficult.

The manager told us that some staff had been making decisions for people and at times had to be reminded to 'ask the person, what they would like'. Staff we spoke with demonstrated a compassionate nature towards the people they cared for, one staff member said: "I love it here, there is choice for people, and we ask people what they want to do on a day to day basis".

People had access to an advocacy service if they required it. We were told one person had an advocate who supported them to make informed decisions when they were not able to do so themselves. This meant that this person was supported in making decisions about their own care through the use of an advocate.

Good

Is the service responsive?

Our findings

People had their own flats within the service. Two people invited us to see their flats and we saw that they had been supported by staff to personalise them to their own individual tastes. People's needs had been assessed prior to admission into the service, their likes, dislikes and preferences had been sought from people themselves and people who knew them well. One person had a swing in their garden. A member of staff told us: "The swing has always been a big part of [Person who uses the service] life, so we had to make sure they had one here, when they moved in".

People and their families had regular meetings with their care staff. These were called 'core' team meetings. We saw that people were asked about what they liked, disliked and what had gone well or not so well. Achievable goals, such as people doing their own household chores were set. One person told us, "I fill the washer up every night before I go to bed, that's my job". People's goals were reviewed at every meeting to ensure that they were still relevant and achievable. Staff also checked that the person was still happy to be working towards them.

People were supported to be involved in the community. One person went swimming with staff. Staff told us they had introduced the activity slowly to so that the person could gain confidence in their surroundings. We saw this person on their return from the swimming pool and saw they looked happy and relaxed following their swim. Staff told us that people chose what that they wanted to do on a day today basis. We saw other people went shopping with support or out for meals.

People who used the service spent small amount of times together in the communal lounge. There was a take away night and birthday parties where people got together. Some people chose not to join in and this was respected by staff. A staff member told us: "[Person who used the service] comes and has a look at what's going on in the lounge but then runs back to their flat laughing, they don't want to join in".

There was a complaints procedure. The manager told us that the procedure had been adapted into an easy read format for people with communication difficulties and that people would be supported to use it with advocates, family members/friends or staff. Relatives we spoke to told us they knew who to complain to and told us they felt they could complain if they needed to.

The manager told us that they planned to implement tenant meetings for people to have a say about how the building was run and managed. They also had plans to implement a key worker system so that everyone had a member of staff who was allocated to care for them specifically. These measures would help to ensure that care was personalised and met people's individual needs.

Requires Improvement

Is the service well-led?

Our findings

Following incidents of abuse the provider had not followed its own safeguarding procedure and staff performance was not managed to ensure the risk of further incidents was reduced. We asked to see a current risk assessment for one person which the manager had told us had been put in place following an incident; the manager was unable to locate it. Staff we spoke to could not tell us what was in the risk assessment and how they planned to reduce the risk of further incidents.

The provider had several quality audits and systems in place, however when areas for improvement had been identified, there were no action plans in place setting out how and when the improvements would be made.

We were told that there were times when there was no senior member of staff on duty. Staff we spoke to told us there was an on call system in the case of emergencies. Staff and the manager told us that the floating member of staff [staff member not allocated to a person's care] was unofficially responsible for ensuring that all staff had support if they needed it. This member of staff was also responsible for the smooth running of the shift when the manager and team leader were not there. Staff told us that this sometimes caused issues and friction within the team. One staff member told us that as they had found themselves being allocated to person's care who didn't like them and although they had reminded the person of this they did not take any notice. This meant that there were no clear lines of accountability in place.

The manager told us that they were currently prioritising the safety of people who used the service and staff supervisions. They had been in post for three months and were in the process of registering with us. We saw that the manager made themselves available to people who used the service and knew people well. Staff and relatives felt that the new manager was making positive changes to the service. A relative told us:" [The new manager] is calm and diplomatic and is gradually getting things done". A staff member told us: "[The new manager] is great, they have a great rapport with everyone, and I can't fault them". A health professional told us that they felt the new manager had been working really hard in difficult circumstances.

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
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and Treatment must be provided in a safe way for service users

The enforcement action we took:
We have required the provider to improve by issuing a requirement action.