Lancashire County Council

Chorley & South Ribble Short Break Services

Inspection report

121 Worden Lane
Leyland
Preston
Lancashire
PR25 3BD
Tel:01772457585
Website:

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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?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We inspected this service on 24 November 2015, this inspection was unannounced. The service was last inspected 29 August 2013 where we found the provider met the regulations we looked at.

Chorley & South Ribble Short Break Services provides short breaks for up to four adults with a learning disability, physical disability or sensory impairment. All accommodation is on the ground floor. Two bedrooms are larger in size, have ceiling tracking and specialist en-suite facilities, suitable for people with physical disabilities. There is ramped access to the home and also to the garden. The home is situated in a residential area close to the centre of Leyland.

Summary of findings

The service has a manager who is currently undergoing the registration process to become the registered manager. 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.

We found that the principles of the Mental Capacity Act 2005 (MCA) were not embedded in practice. The service did not have sufficient systems in place to enable assessment of a person's mental capacity prior to requesting their consent. We have made a recommendation about this.

We found that the incident records for safeguarding incidents had not always been completed. Support plans and risk assessments had not been implemented or reviewed following these incidents. We found that risks were not always well managed and were not kept under review to ensure that people were protected. Support plans contained information that was out of date or there was significant gaps between updates. One person's support plan was implemented in 2008 and was then not reviewed until 2015.We found that incident reporting was not always undertaken, investigated and reviewed. Trends and analysis data was not available.

We looked at medicine administration and found that the service was not following best practice principles when recording medicines that came into the service. We found that improvements needs around medicines management and a recommendation has been made in relation to this.

People spoke positively about the management team and said that they were approachable. We found a positive culture at the service was reported by all the staff members that we spoke to.

There was effective communication between all staff members including the managers. There was an established staff team who knew about people's individual care needs and were passionate about their jobs and caring for others.

We found that there were safe recruitment policies in place and these were followed to help ensure staff were recruited safely. We looked at how the service provided a safe environment for people. We found the service to be clean, tidy and well designed. We found that the service did not always follow safeguarding reporting systems as outlined in its policies and procedures.

People who used the service could follow their own interests and engage in activities both in the home and in the community. We saw that staff had good skills to communicate with people on an individual basis.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to consent, safe care and treatment, safeguarding people from abuse and good governance.

You can see what action we have asked the provider to take at the back 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 consistently safe.

Recruitment procedures were robust.

Improvements were needed with regard to risk assessment and management within the service.

The service did not always effectively report safeguarding incidents.

Improvements were needed around medicines management.

Is the service effective?

Requires improvement

The service was not consistently effective.

People's rights were not always protected, in accordance with the Mental Capacity Act 2005.

The staff team had been provided with a number of training courses and we saw evidence of staff supervision.

People were supported to eat food that met their preferences.

Is the service caring?

Good

The service was caring.

From our observations during the inspection we saw staff had positive relationships with people who use the service, staff interacted with people in a kind and caring way.

We received some positive comments about the staff and about the care that people received.

Is the service responsive?

Requires improvement

The service was not always responsive.

Care plans were person centred and included detailed descriptions about people's care needs however these were not always up to date.

People using the service were supported to take part in activities.

Pre-admission prior calls were not always completed and the information collected was not always adequately recorded by staff.

Is the service well-led?

Requires improvement

The service was not consistently well led.

The manager was open and approachable and the staff team felt supported.

There was a quality assurance system in place to monitor the quality of the

Summary of findings

service being provided. This did not always pick up inconsistences within people's records.

Policies and procedures were out of date which meant staff may not always have up to date guidance available.

Chorley & South Ribble Short Break Services

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.

The inspection team comprised of two compliance adult social care inspectors.

Prior to this inspection, we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us. We received feedback from social work professionals and a district nurse team. Their feedback is included within this report.

At the time of our inspection of this location, there were three people who used the service. We met them and spent some time observing them receiving care and support. However, they were unable to give us verbal feedback. We were able to speak to six relatives of people who used the service on a regular basis. This enabled us to determine if people received the care and support they needed and if any identified risks to people's health and wellbeing were appropriately managed.

We observed how staff interacted with people who used the service and viewed three people's care records. We spoke to four care workers and the manager during the course of our inspection.

We also looked at a wide range of records. These included; the personnel records of four staff members, a variety of policies and procedures, training records, medicines records and quality monitoring systems.

Requires improvement

Is the service safe?

Our findings

People we spoke with said: “The home is always clean and tidy”: “I feel [name removed] is safe and well looked after”: “I feel chilled when [name removed] is there as I know she’s safe” And: “I know I have no need to worry”.

We looked at recruitment processes and found the service had recruitment policies and procedures in place to help ensure safety in the recruitment of staff. Prospective employees were asked to undertake checks prior to employment to help ensure they were not a risk to vulnerable people. We reviewed recruitment records of four staff members and found that robust recruitment procedures had been followed.

We reviewed disciplinary procedure documentation and found that the registered manager had followed procedures. We asked staff if they felt there were sufficient numbers of staff to provide care and support for people receiving at the service. Staff told us: "On the whole there is enough staff and management always listen to requests for extra staff for activities”: "There is always permanent members of staff on with casuals" And: "Yes there is enough staff on at any one time".

We looked at how the service provided a safe environment for people. We found the service to be clean, tidy and well designed. People had space to maintain their independence and adaptive designs such as handrails and bath hoists were in place where required.

Staff told us they knew how to report safeguarding concerns and felt confident in reporting any concerns. We felt reassured by the level of staff understanding regarding abuse and their confidence in reporting concerns.

We looked at how people were protected from bullying, harassment, avoidable harm and abuse. We found that the service did not always follow safeguarding reporting systems as outlined in its policies and procedures.

We looked at a person’s care records. We found evidence of three safeguarding incidents. One of the incidents had been reported to the manager. This was an incident involving two people who used the service. We found that a safeguarding referral had not been made by the service. The person’s social worker made a safeguarding referral regarding the incident following review of their care records.

Two further safeguarding incidents were recorded in the person’s care notes; these had not been reported to the local authority in line with safeguarding adults procedures.

We found that the incident records in relation to these two incidents had not been completed. Support plans and risk assessments had not been implemented or reviewed.

This meant that the service was not following best practice around safeguarding adults.

This amounted to a breach of regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the service protected people from avoidable harm and known risk to individuals.

We looked at three people’s care records. Two of the records we viewed showed significant gaps in the review of risk assessments. The provider’s risk assessments clearly outlined the need for annual reviews.

For example one person’s medicines risk assessment was implemented in 2011 and was not reviewed until 2015. Another person’s risk assessment for interpersonal skills, was implemented in 2009 then was not reviewed until January 2014 and had not been reviewed or updated since.

We looked at personal emergency evacuation plans [PEEPS] for the three people we pathway tracked. We found that annual reviews had taken place, however the provider’s records stipulated that people’s PEEPS should be updated at every stay.

Incident and accident records were last updated in 2011 for people who accessed the service. We found evidence that incidents had occurred during pathway tracking; however these had not been recorded. We asked the team leader why incidents and accidents were not being formally recorded and they explained that staff were using the wrong documentation. We saw that a significant event record was used for some people. However this was not in line with stipulations outlined in the provider’s accident and incident policy.

We found that support plans for two people had not been updated in 2015; however significant gaps prior to this review were evident. One person’s support plan was implemented in 2008 and was then not reviewed until 2015. Another person’s support plan was implemented in 2008 and last reviewed in 2011.

Requires improvement

Is the service safe?

We found that one person was recorded to have ongoing behaviours that challenge. The service had failed to adequately assess the person and subsequently this had resulted in safeguarding incidents. The person's support plan was last updated in 2011. Behaviour management records were last completed in 2012. This person visited the service on a regular basis.

A lack of sufficient risk management for individuals to enable staff to provide safe and person centred care amounted to a breach of regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The third person's risk assessments, with exception of their PEEP, had been updated in line with the provider's expectations. A good standard of information throughout their care plans enabled the reader to understand what was required to mitigate known risks and keep the person safe.

We looked at how the service managed people's medicines. We found that the provider had already highlighted weaknesses around medicines management within the service. We looked at the provider's action plan and found that clear directions for improving systems had been implemented.

We looked at controlled medicines and found that records were not always updated when a person was discharged from the service and had taken their medicines home. Failure to maintain robust recording systems around controlled medicines meant that the service was not effectively monitoring and auditing its daily practices.

We examined medicine administration records [MARs] for three people and found that the service was not following best practice principles when recording medicines that came into the service. Typed MARs showed failings to accurately record people's medicines as stipulated on the medicine dispensary packaging. This meant that people were at risk of not receiving their medicines as prescribed.

MARs did indicate that people received their medicines at the times specified. Records were signed and no omissions were found.

We looked in people's care records and found that calls to parents/care providers prior to the person being admitted for their short stay were not always undertaken. This meant that the service was not always effectively checking if people's medicines had changed.

We discussed improvements needs around medicines management with the manager and team leader and we were reassured by their pro-active joint working, immediate strategies to ensure medicines management was safe were agreed.

We observed medicines administration. We found that safe practice was undertaken and staff worked in pairs to ensure that they checked people's medicines thoroughly before administering. Good standards of hand hygiene were maintained.

We recommend that the provider improves medicines management systems within the service in line with NICE Guidance: Managing medicines in care homes.

Requires improvement

Is the service effective?

Our findings

We asked staff if they received training to help them understand their role and responsibilities. Staff told us: "We get a lot of training": "I get support with any training needs". And: "We have had training around complex needs and if anything comes up we can request further training".

We observed staff support people who lived at the service. We saw that staff had good skills to communicate with people on an individual basis. We observed one member of staff interact with a person who was invading a person's personal space; the staff member approached the person in a calm manner and reminded them about boundaries using effective communication. We saw that the staff member was confident within their role and understood the needs of the person.

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 when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

We looked at how the service gained people's consent to care and treatment in line with the MCA

We asked staff about their understanding of the MCA. Staff told us: "I have an awareness of MCA, I would pass any concerns onto my manager": "We offer choice and use a number of different ways to communicate this to ensure people can understand". And: "I have done training and understand the basics".

We looked at staff training records and found that eight out of 17 staff had received training in MCA and DoLS.

We looked at how the service gained people's consent to care and treatment in line with the MCA.We found that the service did not have sufficient systems in place to enable assessment of a person's mental capacity prior to requesting their consent or asking for parental/care provider consent, in the person's best interest.

For example, in the three care records we viewed parents had signed agreements to various decisions such as 'personal money support plan', 'medication consent' and 'contract agreement'. The service had failed to record that the person's mental capacity had been assessed prior to taking the decision away from them and asking for parental agreement. We did not find any information on people's care records that stated people had lasting power of attorney's rights for finances or welfare.

We looked at 'restrictive practice' records for one person who accessed the service. Restrictions were recorded for aspects of the person's care and support, for example one-to- one care and the use of bedrails. Records stipulated that the decision had been made on behalf of the person because 'we have reasonable belief that [name] lacks capacity'. The service did not formally assess the person's mental capacity prior to coming to these decisions.

Failings identified to adequately assess a person's mental capacity prior to making decisions on their behalf amounted to a breach of regulation 11 (1) (3) (4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We recommend that the principles of the MCA be followed in the absence of the DoLs process for a short break service.

People's care records told us about their likes and dislikes in regards to food and drinks. We saw that the service had a good sized kitchen that could be accessed by people to maintain their life skills and freedoms during their stay at the service.

Staff told us that people's dietary requirements were entered into the diary and shopping was completed prior to their arrival. They were aware of people's individual preferences and ensured they had the correct food taking these into account.

Care records held details of joint working with health and social care professionals involved with people who accessed the service. One person's support plan held details of their speech and language assessment, which gave clear guidance regarding the person's communication needs. We viewed documentation for a hospital transfer and found this information was completed to a high standard of detail.

Staff told us they felt well supported by management and we saw evidence that regular supervisions were being held.

Good

Is the service caring?

Our findings

We saw that staff interacted with people in a kind and caring way. Staff understood the needs of people they supported and it was obvious that trusting relationships had been created.

We received some positive comments about the staff and about the care that people received. One person said: "The staff here are very passionate". Another told us: "Staff are caring and professional and take in the needs of people". Relatives told us: "The staff all know [name removed] well": "Its a home from home; they are fantastic". And "It feels more like a family than a service".

People's support plans showed their circle of support. The information included their key worker at the service, professionals involved at day care services and family links.

Support plans were written with easy read pictures to facilitate people with learning disabilities. However we did not find that people had been actively involved in the review of their care plans. We asked relatives if they felt they were included in plans about their loved ones' care. They said: "I always get a phone call before they are due to visit to see if anything has changed". And "I can always ring up with information if needed and the staff listen".

The home had policies and procedures that covered areas such as confidentiality, privacy and dignity.

We saw that people had individual bedrooms when they stayed at the service. People had their own space that facilitated privacy and independence. People's individuality was maintained and they were able to maintain their independence within the home.

A professional told us: "Staff were very respectful of a person's wishes to remain in their own room during their stay as they didn't want to mix with others". This showed us that staff respected the wishes of others and were person centred in their approach.

Requires improvement

Is the service responsive?

Our findings

Relatives told us that their loved ones enjoyed visiting the service. One said: "They have been going there a long time and seem to really enjoy it": "[Name removed] is always happy when they are going to the service". And: "[Name removed] loves going".

We observed staff interact with people who lived at the service. Staff providing support understood people's individual needs and we saw that person centred care was central to their support services.

People using the service were supported to take part in activities both in the home and in the community. Relatives told us: "They go out to the football": "They go to the pub and to the garden centre". And: "They get about and are always well occupied".

Staff told us they were aware in advance of who would be using the service and when. One staff member told us: "We have someone coming in soon who's had a change in need so we are attending some training to help care for them". This showed a person centred approach and that the service were responsive to people's changing needs.

The provider had a system in place for calls to be made to people's parents/care provider prior to and after they had been for a stay at the service. We found that this system had not been maintained for some time. The new manager had discussed with staff the importance of collating information prior to the person being admitted and this was recorded in recent staff meeting minutes. However when we spoke with relatives, it became apparent that calls were taking place on a regular basis but there was a lack of recording of this information.

We looked at three people's care records. Support plan detail for one person was up to date, individualised and included their preferences, likes and dislikes.

Some support plans that we looked at were thorough and in depth. These plans included aspects of the person's daily routines that helped staff understand their preferred support and what was important to them. For example 'what activities I enjoy', 'what people admire about me', 'what is important to me' and 'what is important for me'.

There was a complaints procedure in place. One relative who had made a complaint in the past told us: "My complaint was acknowledged and a response circulated". We found minimal information with regards to complaints and concerns. The service did not evidence how they managed information around complaints and concerns. This shortfall meant that complaints could not be monitored to improve service delivery. This was discussed with the manager and they recognised that professional recording at the service is an are of improvement.

Requires improvement

Is the service well-led?

Our findings

We found a positive culture at the service was reported by all the staff members that we spoke to. Staff told us that they felt well supported by management. They said: "Management support is really good, they are flexible": "Management have an open door policy". And: "The management team are always around and available to speak to".

A relative told us: "I know I can contact them with any concerns and they would be dealt with".

Professionals we spoke with told us: "The service is ran smoothly". And: "The manager is very approachable".

There was effective communication between all staff members including the managers. Staff received daily verbal handover, and we saw evidence of regular staff meetings that covered more strategic issues such as medicines best practice, staffing issues and updates. We saw that the team were assigned individual areas of responsibility to cover medicines and money.

We found that incident reporting was not always undertaken, investigated and reviewed. Trends and analysis data was not available. This was due at large to the documentation used to record incidents by the staff, which did not allow for analysis. The incidents had not been audited or overseen by management.

The shortfalls in quality assurance and risk management amounted to a breach of Regulation 17 (1) (2) (a) (b) (c) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there was a lack of management oversight of care and support, which could put people who use the service at risk.

A service improvement plan was in place and was monitored and updated regularly by managers. Areas identified for improvement were, compliments, comments and complaints, community health links, dignity in care and involvement meetings for people who use the service. We saw that some of the issues we raised, particularly around MCA were listed on the plan as areas for improvement.

We found that a quality assurance policy was in place and saw that audits were undertaken as part of the quality assurance process. The area manager conducted a monthly service audit and quality monitoring visit. Areas audited were safety and safeguarding, maintenance, restrictive practice and staffing. However audits did not always pick up inconsistences within people's records. For example the time gaps between reviews where incidents had occurred. One person was recorded to have on going behaviours that challenge however the person's support plan was last updated in 2011.

There was evidence of a customer survey that had been undertaken in January 2015 and follow up calls were being completed. There was some analysis of the findings in relation to the specific questions and the responses were generally positive. We were told by the senior team manager that the information was used to improve services.

Prior to our inspection, we examined the information we held about this location, such as notifications, safeguarding referrals and serious injuries. We found that although notifications were received we had not always been notified about things we needed to know about by the manager. An example of this identified when reviewing one persons care file. We found a safeguarding incident involving two people who used the service. We found that a safeguarding referral had not been made by the service to the local authority or to CQC.

This resulted in a breach of Regulation 18 (2) (a) (b) CQC (Registration) Regulations 2009.

A wide range of written policies and procedures provided staff with clear guidance about current legislation, such as safeguarding, medication, record keeping and positive behaviour support. However these had not been regularly updated and reviewed, the last update was 2010. The provider informed us that the updated policies and procedures were available online.

We recommend that the provider ensures the most up to date policies and procedures are made readily available to staff.

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 **The provider did not have suitable arrangements in place to protect service users from abuse and improper treatment. Regulation 13 (1) (2) (3).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The provider did not always inform us of incidents that require submission of a statutory notification to the Care Quality Commission.** **Regulation 18 (2) (a) (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not have suitable arrangements in place to make sure that care and treatment was provided in a safe way for service users.** **Regulations 12 (1) (2) (a) (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider did not have suitable arrangements in place to ensure that the treatment of service users was provided with the consent of the relevant person in accordance with the Mental Capacity Act 2005.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	Regulation 11(1) (3) (4)
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service provider must ensure that there is a robust system in place that can monitor the quality of service provided. Regulation 17 (1) (2) (a) (b) (c) (f)