# Axiom Housing Association Limited

# The Spinney

## Inspection report

Neath Court
Eye
Peterborough
Cambridgeshire
PE6 7GH

Tel: 01733295524

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06 July 2017

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15 August 2017

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

The Spinney is registered to provide personal care to people living in their own flats within an extra care scheme in Eye near the city of Peterborough. At the time of our inspection a service was being provided to older people, people living with dementia, people living with mental health conditions and people living with physical disabilities or sensory impairment. There were 43 people being supported with personal care and 24 care staff employed during this inspection.

This comprehensive inspection took place on 6 July 2017 and was unannounced.

There was a registered manager in place. However, they were not present during this inspection and had been away from the service since February 2017. Since February 2017 a registered manager from another service had supported the care team leader with the day-to-day running of the service. 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.

People were at risk because appropriate systems and processes were not in place to keep them safe and staff had not protected people from harm. When safeguarding incidents had happened, referrals to the local authority safeguarding team had not been made. This meant that staff and management had not reported incidents where people had been harmed.

Risks to people who used the service were not identified and systems were not in place to assess and manage all risks to people. Staff understood some of these risks but not how to minimise them for people whose behaviour was at times challenging.

Notifications, which provide information about important events, had not been sent to the commission as required by law.

The provider's policy on administration and recording of medication had been followed by staff. Audits in relation to medication administration had been completed and had identified areas of improvement required.

People had had their needs assessed and reviewed so that staff knew how to support them and maintain their wellbeing. People's care plans contained person centred information. Staff treated people with care and made sure that their privacy and dignity was respected all of the time. There were sufficient numbers of suitably trained staff to provide and meet people's health and care needs.

Staff understood the principles of the Mental Capacity Act 2005 (MCA) and could describe how people were supported to make decisions. Training had been provided and staff were aware of current information and

regulations regarding people's consent to care. This meant that there was a reduced risk that any decisions, made on people's behalf by staff, would not be in their best interest and as least restrictive as possible.

The provider had a recruitment process in place and staff were only employed in the service after all essential safety checks had been satisfactorily completed. Training was available for all staff which provided them with the skills they needed to meet people's health and wellbeing requirements.

People were involved as far as possible, in how their care and support was provided. Staff checked people's health and welfare needs and acted on issues identified. People were supported to access health care professionals when they needed them. Where this support was required, people were provided with a choice of food and drink.

People and staff were able to provide feedback and information about their view of the service. There were systems in place to monitor and audit the quality of the service provided and to drive forward any necessary improvements. However, these had not always identified all areas requiring improvement.

There was a system in place to record complaints. These records included the outcomes of complaints and how the information was to be used by staff to reduce the risk of recurrence.

Staff meetings, supervision and individual staff appraisals were completed. Staff were supported by a registered manager from another service, a care team leader and a senior carer during the day. An out of hours on call system was in place to support staff, when required.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

## 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.

People were not protected from harm because risks were not identified, assessed and managed.

People were at risk because appropriate systems and processes were not in place to keep them safe from harm. Referrals to the local authority safeguarding team had not been made.

People's prescribed medication was administered by staff who followed safe practices and the providers policy. Medication audits were in place and areas of these identified where improvements were needed.

The recruitment process ensured that only suitable staff were employed to work with people they supported.

### Is the service effective?

**Good**

The service was effective.

People were supported by staff who had the necessary skills and competencies to meet people's individual needs.

Staff had received training and understood the principals of the Mental Capacity Act 2005.

People had access to healthcare professionals when they needed them.

People had enough to eat and drink and their dietary needs were met.

### Is the service caring?

**Good**

The service was caring.

People's dignity, privacy and independence were respected. People were involved and included in making decisions about what they wanted and liked to do.

People received care that was kind and caring.

## Is the service responsive?

Good

The service was responsive

Care plans were up to date and sufficiently detailed.

There was a system in place to receive and manage people's concerns and complaints. Outcomes from complaints and concerns had been used to reduce the risk of recurrence.

People were involved in the assessment of their health and social care needs. People's needs were kept under review to ensure their planned care was appropriate to their needs. People received individualised support from staff who were responsive to their needs.

## Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a registered manager in place.

The commission had not been notified of incidents, which had occurred in the service, and are required by law.

Quality assurance systems were in place to monitor and improve the service but the quality and safety of people's care could not be assured.

# The Spinney

**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 checked 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 6 July 2017 and was unannounced. The inspection was carried out by one inspector.

Before our inspection we looked at information we held about the service including notifications. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with three people who used the service and four relatives. We spoke with the care team leader, registered manager of another of the provider's services who attended to support the care team leader, one senior carer and one staff member.

We looked at four people's care records, staff meeting minutes and medication administration records and audits. We looked at compliments and complaints. We checked records in relation to the management of the service such as staff training records. We looked at the customer quality assurance survey 2016. We saw the local authority contracts monitoring report.

Requires Improvement

# Is the service safe?

## Our findings

People were not always kept safe, because staff had not reported or recorded incidents of harm. As a result, the information from at least five incidents had not been escalated to the provider's safeguarding and quality assurance manager. This meant that there had been no investigations or actions in relation to the incidents to reduce the risk of recurrence. The local authority, the lead authority on safeguarding concerns, had also not been informed.

Staff told us they had received training in how to protect people from harm. They were aware of the types of abuse, how to report any incidents to the management and if necessary telephone other agencies such as the local authority safeguarding team, police or GP. However, it was evident that staff did not recognise abuse if it was between two people living in the extra care scheme. The safeguarding and quality assurance manager confirmed that information was not in the provider's current safeguarding policy in relation reporting incidents of harm between people in the service. However, there was information in the provider's behaviour management policy that staff had not followed. This stated that staff were to report safeguarding events between people in the service to keep them safe.

This was a breach of Regulation 13 (2) of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

People were not always kept safe because the provider did not have systems in place to identify, assess and manage any potential physical risks and health risks. Staff had not always recognised the level of risk to people and had not managed effectively to minimise the risks occurring. For example, we saw that two people displayed significant behaviour that was challenging to others; however, there was no information on how staff should de-escalate situations to try to prevent them from recurring. Managers confirmed that there were no risk assessments in place in relation to people's behaviour that was difficult to manage. This put the people, other people living in the service and staff at risk. Staff said they had not had training in how to de-escalate behaviours that challenged and this was confirmed by the managers on the day.

This was a breach of Regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

There were some records of accidents and incidents, which demonstrated that actions had been taken to reduce the risks of repeated occurrences. For example there had been an issue in relation to one person's level of falls. Information and discussions with staff, showed that agencies such as the falls team, occupational therapy team and GP had been involved. Staff were aware of the provider's policy and one staff member said, "I get the [incident/accident] form from the office and give it to the manager." During the inspection an incident occurred. Staff dealt professionally but sensitively with the person. We saw later that an accident/ incident form had been completed.

There were sufficient numbers of staff to meet the needs of people they supported; and staff confirmed this to be the case. People told us they had regular staff although there were some times when agency staff

provided their care. One person said, "I get regular carers unless they have a day off. Sometimes there is an agency lady but she's very nice." They went on to say that there was continuity as the same agency staff came regularly. Staff told us that if staff went off unexpectedly through sickness or agreed annual leave they would cover the shifts where possible. Although, agency staff were used when necessary. One staff member said, "We [staff] give a months' notice for holidays. We come and do extra [shifts] or get agency [staff]. We last used agency [staff] a few weekends ago."

We looked at the local authority monitoring report dated November 2016. We saw information from the provider's head office staff, and discussions with managers showed that safe and effective recruitment and selection processes were in place. These processes ensured staff were of good character, physically and mentally fit for the role and able to meet people's needs.

People were administered their prescribed medications as detailed in the provider's policy on medication administration. One person told us, "They [staff] put everything down [record when person had their medication]." Another person said, "The young ladies [staff] do give me my tablets. They give them regularly." A relative confirmed that their family member had the medication they had been prescribed by the GP. We saw that staff had recorded the number of tablets administered where there was a choice of either one or two tablets to be taken. There were body maps to show where creams should be applied, which meant people had their creams as prescribed.

Information from the care team leader, and staff, confirmed that training in medication administration had been provided and they attended regular updates each year. People had medication consent forms in their files to show they agreed for staff to administer their prescribed medication. A medication assessment tool was completed for each person which looked at the level of support they would need from staff. The registered manager from another of the provider's services said that a new method of medication administration was being looked into to improve medication management.

Good

# Is the service effective?

## Our findings

Staff told us they completed yearly training to refresh and update their skills and knowledge. Staff told us, and records confirmed that they had completed other training specific to their roles. One staff member said, "I have NVQ Level 2 [in Health and Social Care] and a diploma in dementia."

There was a training plan in place which identified when staff needed to complete the updates for on-line courses. This meant that people were being looked after by staff who had received training to support and meet the needs of people living in their own flats. People and their relatives did not make any specific comments about staff training but felt staff knew how to provide them with the support they needed.

Staff confirmed that they received one-to-one supervision on a regular basis and an appraisal each year. One staff member said, "I have one-to-one supervision that is written down and I had my yearly appraisal not so long ago." We asked a staff member what was discussed in a one-to-one supervision and they said, "We are asked if we are happy [in the work], any training we need and any changes we could make to provide better care."

We checked to find out if people were being looked after in a way that protected their rights. We found that the provider was ensuring that people's rights were respected in line with the Mental Capacity Act 2005 (MCA). The 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.

We checked whether the service was working within the principles of the MCA. We found that people's rights were being protected from unlawful decision making processes. Staff confirmed they had received training in MCA and DoLS. At the time of our inspection the staff we spoke with said that most people who received personal care support had the mental capacity to make decisions about their care. One staff member when asked about mental capacity said, "It's if you cannot make your own decisions and need help from family or maybe social services. You treat people with the same respect, keep people safe and secure and with their best interests at the heart."

People and their relatives told us they/their family member made choices every day and that these choices were respected. One relative told us, "Mum should rest in the afternoons but chooses not to." The person agreed. Where people were unable to make some choices relatives told us staff still asked the person. They went on to say, "They know her and what she likes." Staff told us that they ensured people could make choices wherever possible and offered "perhaps two [different choices] for people who found it difficult to choose." For example people could choose the meals and drinks they wanted, could remain in their flat or come into the lounge or dining room and made choices about their clothing and what they would like to wear.

We checked and found people's nutritional health was being met. People we spoke with told us they were

able to have meals provided in the extra care dining room and kitchens, which were not part of the domiciliary care service. People told us that staff always left them with enough drinks in their flats to maintain their hydration. One person said, "I go down to the dining room for meals. At tea time they [staff] give me a sandwich and drink." We saw that the person had a drink next to them and they said staff had asked what they wanted before they left.

We found that people's health and well-being was being met. During the inspection a person fell and we saw that staff had called the emergency services and paramedics arrived to deal with the event. Relatives told us they had been telephoned about the person falling and arrived as quickly as possible. Staff told us that there was a procedure in place if people became unwell or fell. They confirmed that they would call other professionals such as the emergency services, GP, occupational therapist or District Nurse when necessary. There was information in people's care records that showed that health or social care professionals had been contacted appropriately. A relative confirmed that they were happy with how their family member was supported by other health professionals. They said, "The district nurse comes twice a week. The district nurses discuss things with the carers and the carers get in touch [with the relative] when they need to."

Good

# Is the service caring?

## Our findings

People and their relatives were very positive about the staff who provided the care and support in the extra care scheme. One person said, "The [staff] look after me 100 per cent. They are very thoughtful. I have never been as happy." Another person said, "The carers are very good. I can't complain at all. I wouldn't want it any other way. The office staff and kitchen staff are very good too." A relative said, "I can't say enough good things [about the staff]. I tell everyone. When I come I always find [family member] clean, dressed and has had breakfast. They [staff] treat [family member] as if they were doing it for their mum."

People using the service and their relatives told us they were involved in decisions about their needs and how they wished to be supported. There was information in people's files that showed they had been involved in the assessment of their needs.

People and their relatives told us that they understood the plans about their care and that their views were important and had been listened to. One person said, "I came here from hospital." The person confirmed that an assessment had been made before they came into the extra care scheme. Staff told us that they were informed if there had been any changes in individual people's care and support needs but they always still read the care plans and risk assessments when they went to the person's flat to provide their care. Two staff members told us about the support they provided for people. We looked at the person's care records and saw that the staff members were providing them with the care they wanted. This meant people could be assured that the support the staff provided was correct and up to date.

People and their relatives confirmed they usually had regular staff to support them. Staff told us there were times when agency staff were used but usually people received support from the same staff. One relative confirmed that their family member received care from staff who knew them. They said that if agency staff were used for their family member then there was always a regular staff member who accompanied the agency staff. Staff said there was always sufficient information in the person's flat to enable them to meet people's care needs.

Staff told us how they ensured people's dignity and respect was maintained. One staff member said, "I would cover them [people using the service] half way when washing them. In their bedroom I would pull the curtains and shut the doors."

People were enabled to remain as independent as possible and remain in their own flats with support from staff in the service. One person spoke about being as independent as possible and said, "I couldn't wish to live my life better." Another person told us, "I can do what I like. If I don't want it I don't have it." Information in the local authority contracts monitoring report showed that 'where a person was able to be independent, or partially so', this was noted in the person's care plan as guidance for staff.

Good

# Is the service responsive?

## Our findings

We sat with people and their relatives and looked at their care plans with them. The information in the care plans was individualised and detailed so that staff were able to meet people's needs. For example, people who had requested only female staff for their personal care told us that they had female staff provide it. One relative said that their family member did not want male carers for their personal care. The relative and person confirmed that personal care was provided by a female staff member.

People and their relatives told us they were involved in the assessment and regular reviews of the care and support being provided by the service. For example, one relative told us about the reviews that were completed saying, "There is a review every six months, or before, or 12 months if nothing needs to be changed." People had information recorded in their files to show if they wanted to be involved in their reviews or changes in their care needs. Another relative told us that changes had been made in their family member's care. They said, "It [care plan] is reviewed. They [staff] now do more [for family member] than originally agreed. If [name of person] is poorly they call intermittently during the day and night." People and their relatives told us that staff listened to them and that there were opportunities to talk about their changing needs or any concerns about the service.

Staff were aware of how to meet the care needs for each person and could provide the consistent support that people needed. Staff were able to tell us about the care and support people received. They told us about the things people enjoyed doing, the areas people wanted help with as well as those areas they wanted to retain as much as possible in relation to their independence. One staff member said, "We know where people have come from, what they like, whether they like a bath or a shower and what medication they are on." Another staff member said, "We get to know the family, their background, their likes and dislikes, food and tablets [medication]. We need to know, especially if the resident [person using the service] has dementia. Perhaps they like singing, picking strawberries, things you can know through their history." The staff member went on to explain that by knowing the person staff could re direct their activities if they (the person) was unhappy or became agitated.

People were protected from the risks of isolation and loneliness because the service provided activities that encouraged people to maintain their hobbies and interests. One relative said, "[Family member] likes bingo. They [staff] bring her and include her. They entice her down so that she's not left in her [flat]." There were areas where people could sit and chat as well as dining areas where they could purchase a meal and sit with other people. We saw that people came into the lounge area prior to the lunchtime meal and sat in groups chatting. We saw that people had been asked their views on activities during the meetings held at the service. The minutes of the May and June 2017 meeting minutes were seen and showed discussion about the summer fete, Christmas Bazaar and Christmas Pantomime. There was evidence that entertainment had been provided weekly. People we spoke with told us that they could choose to attend if they wished. One person said, "I go out with my [relative]. They [service] have activities but I don't go." A relative told us," There are memo's that show what they're doing in the next six months, things like trips." We saw the last memo which showed there was a chat and chuckle event, music, church services and the dementia café.

There was a policy and procedure in place from the provider on how to deal with concerns or complaints. Staff told us how they would help a person they were caring for make a complaint if they wished to. People knew how to make a complaint and had the necessary telephone numbers in the service folders in their flats if they needed to do so. One relative told us they had raised some minor issues with the office staff and had been satisfied with the response and said, "They sorted things out." Another relative told us they would inform the care team leader or senior carer if they wanted to raise any concerns but had not had to do so. Information in the complaints log showed that the management had investigated, responded and ensured that lessons were learned to improve the service. This was done for example through discussion with the staff team or changes to care plans to ensure the event did not reoccur.

Requires Improvement

# Is the service well-led?

## Our findings

The management was not aware of all the incidents that occurred within the service that they were legally obliged to inform the Care Quality Commission (CQC) about. Records we held about the service, and looked at during our inspection confirmed that some notifications had not been sent to the CQC as required. A notification is information about important events that the provider is required by law to notify us about.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider had a system in place to monitor and improve the quality of the service. There was an audit process to check the records returned from people's flats. Books contained the daily notes recorded by staff and there were also medication administration record (MAR) charts. The audits were completed and then signed as correct by senior staff. The MAR charts had been audited and issues found discussed at staff meetings and addressed with individual staff members where necessary. However, other checks in relation to the welfare of people living with dementia had not found the issues relating to their behaviour and the consequences of those behaviours. This meant that the audits were not always robust and issues had not always been investigated and actioned to reduce the risk of recurrence.

The registered manager of another service said that people's views, about the quality of the service provided, were taken into account. There were internal quality assurance inspections, the last of which was in May 2017. Information showed that after the provider's internal inspection an action plan had been put in place. The areas of concern noted in the action plan had been addressed or were ongoing where the issues needed to be actioned and consolidated. For example, outstanding accidents & incidents had been sent to the administrator for logging, ensuring regular staff supervision and any changes in people's medication to be recorded by two staff. However, we found that records of accidents and incidents around the behaviours of people living with dementia had not been checked as part of this monitoring. This meant the provider's quality assurance system had not always been robust and the findings were not always a true reflection of the outcomes for people at the service.

People and their relatives told us they were provided with information through newsletters and memos. One relative said, "The newsletter tells you things that are happening but it has been hit and miss." They went on to say that the newsletters had not been sent out regularly since the registered manager was absent. People told us they were asked every day by the care staff and management about the care they were receiving.

We checked to find out how the service was being managed. There was a registered manager in post but they were not in the service at the time of the inspection. During their absence the day-to-day running of the service was supported by a care team leader, two senior carers and 22 care staff. Since February 2017 a registered manager from another service had supported the care team leader.

People were happy about the way the service was managed. One relative said, "We mostly see [name of care team leader]." There were residents meetings and we saw the minutes of meetings held in April and June 2017, which included updates from previous meetings. The minutes showed how people were encouraged

to comment about any areas of the service. We saw that people had requested the minutes of the residents meetings be e-mailed to 'residents/family etc.' People were asked to provide the necessary e-mail addresses for that to be done. However, we noted that most of the discussions were around the building and meals services which the domiciliary care service does not provide.

People were able to contact staff through an out of hours telephone system through their lifeline pendant or bracelet (emergency call bell system) if they needed assistance during the night. One person said, "I just pip this [lifeline for emergency calls] and they [staff] are here." One relative told us, "There's always someone [staff] around and [family member] pulls her lifeline if she needs to." Staff told us that they had telephone numbers for on call management so that they could be supported out of normal working hours and in the event of any emergency.

Staff told us they felt supported by the registered manager and senior staff. One staff member told us when the registered manager was there she was, "Very good. You can go to her with anything, any problem, but we need a manager here. [Name of care team leader] and the seniors are supportive but it's best to have a manager full time [in the service]."

Staff told us there were usually monthly meetings where they could discuss concerns or suggest ways to improve the service. One staff member told us that they had discussed how staff could have positive feedback during meetings. They told us the registered manager had said they would look into it as there used to be 'rewards' if staff for example had good attendance. We saw minutes of the April 2017 team meeting. The minutes included actions taken from the previous meeting; information about issues arising from staff practice such as MAR chart completion; completion of accident forms to be more detailed and team work. There was also feedback from a previous discussion and improvements that were needed in relation to medication administration. This showed staff had been provided with the appropriate information in relation to areas of their work and the ways in which they needed to improve the service.

People could be confident that there were procedures in place to review the standard of care provided by staff. This was done through monitoring by senior staff who visited care staff during their visits to people and checked staff competence in care and medication administration.

Compliments made by people using the service and their relatives showed that staff upheld the values expected by the provider. Comments from the provider's quality assurance questionnaires included, "I enjoy living here and the carers are very good to me"; "I'm always happy to see my carers, they help me a lot;" and "All the carers are brilliant. They all work extremely hard." This showed that care staff were aware of the values and aims of the service.

Staff told us that the service had a policy and procedure in place in relation to 'whistleblowing' so that they could report any poor practice and would do so if necessary. One staff member said, "I would report someone [staff] if they were not treating people right. I haven't had to do that." Staff felt they would be supported but had never had to raise a whistleblowing concern.

There was information that the Peterborough City Council Contract Monitoring department had completed an inspection in February 2016 and a report written. The report showed the service was assessed at 89.1 per cent compliance and there were several areas of recommendations for the service, which were being worked on by the provider under its continual improvement programme.

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 18 Registration Regulations 2009 Notifications of other incidents<br><br>The Commission had not been notified without delay of incidents that had occurred. Regulation 18 (1) (2) (e)(f)(g) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>People were not kept safe because risks had not been assessed or managed effectively. Regulation 12 (2) (a) (b) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>Appropriate systems and processes were not in place and staff had not protected people from harm. Regulation 13 (2) |