

East Living Limited

Wakeling Court

Inspection report

96a Halley Road
Forest Gate
London
E7 8DU
Tel: 020 8472 9648
Website: www.east-thames.co.uk

Date of inspection visit: 15 October 2014
Date of publication: 13/02/2015

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

The inspection took place on 15 October 2014 and was unannounced.

Wakeling Court is a 22 bedded residential care home which provides accommodation and support to adults with mental health needs. Eighteen people were using the service at the time of our inspection. The service had a 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.

Medicines were not always recorded in a safe manner which put people at risk. You can see what action we told the provider to take at the back of the full version of the report.

There were enough staff working at the service to meet people's basic needs and promote their safety. However, more staff were needed to meet needs beyond basic care.

Summary of findings

The service was aware of how to deal with any allegations of abuse. Risk assessments were in place to promote people's safety and people were supported to take risks in a safe manner.

No one living at the service was subject to a Deprivation of Liberty Safeguard authorisation. Mental Capacity Assessments were carried out, but this was not always done in line with the principles of the Mental Capacity Act 2005 and we have made a recommendation about this. Staff undertook various training and had supervision with their manager to help support them in their duties. People told us they liked the food provided and we saw people had a choice of food. People had access to health care professionals as appropriate.

People were treated with respect and dignity by the service. The service took steps to promote people's choice, privacy and independence. Care plans were in place for people which set out how to meet their assessed and individual needs. Staff had a good understanding of the needs of people.

The service had a clear management structure in place. People and staff told us they found the registered manager to be accessible and approachable. The service had a complaints procedure in place and we found complaints were looked into and investigated appropriately. The service had various quality assurance systems in place. Some of these included seeking the views of people that used the service.

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?

People were not safe. Medicines were not properly recorded at the service which meant medication errors were more likely to occur.

There were enough staff to meet people's basic care needs. However, more staff were needed to meet people's overall needs such as developing their independent living skills.

Systems were in place to reduce the possibility of abuse and staff had a good understanding of their responsibility with regard to safeguarding adults.

Risk assessments were in place which included information about how to manage and reduce risks. People were supported to take risks in a safe manner.

Requires Improvement



Is the service effective?

The service was not effective. It did not have effective systems in place for assessing people's capacity to make decisions. People did not have their freedom of movement restricted by the service and no one was subjected to a Deprivation of Liberty Safeguard authorisation.

Staff undertook regular training and had supervision from their line manager to help support them in their job.

People had a choice of food and were supported to eat sufficient amounts. The service worked with relevant professionals where a person was at risk related to nutrition and hydration.

People had routine access to health care professionals and the service supported people to be healthy.

Requires Improvement



Is the service caring?

The service was caring. People were treated with respect and dignity by staff and were able to make choices about their care and daily lives.

The service met people's needs with regard to equality and diversity issues and communication.

Good



Is the service responsive?

The service was not responsive. There were not enough staff to meet people's needs in relation to activities and developing their independence.

People were involved in planning their own care. Care plans were in place which set out how to meet people's individual needs. These were regularly reviewed to reflect changes in people's needs.

Staff had a good understanding of how to support people and meet their needs in a personalised manner.

Requires Improvement



Summary of findings

The service had a complaints procedure in place. People knew how to make a complaint and we found complaints were investigated appropriately.

Is the service well-led?

The service was not always well-led. Audits were in place but these had failed to highlight poor practice with regard to medicines and mental capacity assessments. The service had a clear management structure in place. Staff and people who used the service told us the managers were accessible and approachable.

Quality assurance systems were in place. Some of these included seeking the views of people on the running of the service.

Requires Improvement



Wakeling Court

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 15 October 2014 and was unannounced.

The inspection team consisted of a Care Quality Commission inspector, a specialist advisor with specialist knowledge of working with people with mental health needs and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at the information we held about the service. This included details of its registration, safeguarding alerts and information the provider had sent to us in the form of notifications. During the inspection we spoke with five people that used the service and six staff that worked at the service. This included the registered manager, the deputy manager, the cook and three support workers.

We observed care being provided and examined various records. Records we examined included six sets of care notes relating to people who used the service, training records for all staff, supervision and annual appraisal records for six staff, minutes of staff meetings and residents meeting, medication records and various policies and procedures including complaints, whistleblowing and safeguarding adults procedures.

Is the service safe?

Our findings

We found concerns with the recording of medication. We checked the medicines administration record (MAR) charts for six people. We found two of these contained several unexplained gaps for the period between the 6 and 15 October 2014. This meant it was not possible to verify if the medicines had been administered correctly. We checked the amounts of seven medicines held in stock against the amounts that should be held in stock according to the records. We found there was a discrepancy in one of the medicines.

Where people had been prescribed medicine on an 'as required' (PRN) basis such as Lorazepam there was no guidance in place about when staff should administer it. This increased the risk of it being administered when not required or not being given when people needed it. We found one person needed to have their medicine tablets crushed and dissolved in water due to swallowing difficulties. However, there was no care plan or guidance in place for staff about how to do this. This increased the likelihood of mistakes being made and left people at risk because they may not be given their medicine as prescribed. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that medicines were stored securely in locked and designated medicine cabinets. These were located in the service's office and in people's bedrooms. Some people had been assessed as safe to administer their own medicines and were supported to do so. This helped to promote their independence. We found that staff carried out regular checks where people administered their own medicines to make sure it was safe. Medicines were administered by care staff that had undertaken training about the safe administration of medicine.

We found there was enough staff to meet people's basic needs and keep people safe. However, we found that staffing levels were such that the service was not able to do much more for people than meet their basic needs and keep them safe. One member of staff said they made sure people received personal care, attended appointments, had sufficient to eat and drink and got their medication on time. However, they said this left them very little time for

anything else. For example, they told us they were supposed to have time set aside for administration work but often were not able to do this because they had to work with people as their immediate needs took priority over paperwork.

The service had a safeguarding adult's procedure in place. This made clear the services responsibility for reporting any allegations of abuse to the relevant local authority. However, it stated that safeguarding allegations should only be reported to the Care Quality Commission (CQC) 'where necessary'. All allegations of abuse that are reported to the local authority must also be reported to the Care Quality Commission. The registered manager told us they would discuss this with the provider so that the procedure could be amended.

The registered manager told us they had made one safeguarding referral to the local authority since our last inspection but the local authority decided it was not a safeguarding matter. This showed the registered manager was aware of their responsibility for reporting suspected abuses of people to the local authority safeguarding team.

Staff had a good understanding of their responsibility with regard to safeguarding adults. They were aware of their responsibility to report any allegations of abuse and told us they had undertaken training about this topic. Training records confirmed staff had received this training.

There was a document called 'Say No To Abuse' in people's care files. This was a guide to adult safeguarding and what service users could do if they had concerns.

Risk assessments were in place for each person detailing the individual risks they faced. The risk assessment documents were well designed and encouraged the assessor to think positively about risk and consider strengths as well as concerns. For example, one risk assessment focused on diabetes. It recognised the person struggled with maintaining a healthy diet and so the key worker and the person agreed to have a weekly meeting where the person developed a menu for the week and the key worker advised on this in terms of reducing sugar and fat content. We saw records of these meetings. This meant the person was able to take some control for managing their own risks and enabled them to make informed choices with regard to risk.

Is the service effective?

Our findings

We found that assessments were carried out to determine if people had the capacity to make decisions. However, we found that assessments were not always properly recorded. For example, assessment documents we examined were poorly completed and did not demonstrate how decisions had been reached. We saw on one assessment the assessor had ticked no to a question about the person's ability to understand the information, retain it, weigh that information in the balance or communicate their view, but no information was provided as to why they ticked no. The person in question had no communication difficulties so it was not clear why they were assessed as being unable to express their view. The registered manager told us that the forms used for carrying out assessments were not a good tool for this purpose. However, they said that new improved forms had been produced for carrying out assessments of people's capacity and the service was in the process of implementing these for people. If mental capacity assessments are not carried out in line with the principles of the Mental Capacity Act 2005 people's capacity may be wrongly assessed meaning people are deprived of the right to make decisions for themselves. Although staff had a good understanding of issues relating to the Mental Capacity Act 2005 assessments were at times poorly recorded. **We recommend that** the provider consider the Mental Capacity Act 2005 Code of Practice when reviewing their consent and capacity assessment procedures.

People told us there were no restrictions placed on their freedom. One person said, "I can come and go as I please." Another person told us they had a key to the front door of the service. The registered manager told us that no one living at the service was subject to a Deprivation of Liberty Safeguards (DoLS) authorisation and no one needed to be. This was because people's liberty was not restricted. People told us this was the case and that they were able to come and go from the service as they chose.

Staff told us and records confirmed that they had undertaken training about DoLS and the Mental Capacity Act 2005. Staff told us they supported people to make choices. For example, in relation to their personal care, their clothes and food.

Staff told us they undertook various training courses. These included health and safety related topics such as fire safety, moving and handling and infection control. Staff also

undertook training designed to help them better to support people's needs. For example, training about working with people with mental health needs and care of older people. The service provided us with a copy of their training matrix. This showed a wide ranging training program was available to staff to support them in their roles. Training provided included understanding suicide intervention and nutrition and hydration. Training records showed staff completed the Common Induction Standards on commencing work at the service. Common Induction Standards are the standards people working in adult social care need to meet before they can safely work unsupervised.

Staff told us they had regular one to one supervision meetings with their line manager. They said they found these to be helpful and were able to discuss any issues of importance to them. The registered manager told us they had supervision with their line manager every four to six weeks and it was their expectation that staff working at the service would have the same level of supervision. We examined supervision records which confirmed this frequency. Records showed staff discussed issues including training needs, staffing issues and issues relating to people who used the service. Staff also had an annual appraisal of their performance designed to develop improvement and good practice and we saw records of this.

People told us they liked the food at the service. One person said, "Food is very nice." Another said, "Food is good." People told us they were able to buy their own food and had cooking facilities in their rooms. We observed that people were able to prepare their own meals and saw one person supported by staff to cook a meal reflective of their cultural background. We observed that most people ate meals prepared by designated cooking staff. Choices were available including a vegetarian option.

We saw that where the service had concerns about people being at risk related to nutrition and hydration they involved relevant health professionals in people's care. People told us the service supported them to eat a healthy balanced diet. One person told us, "Staff come with me to the dietician." Records showed that referrals were made to the GP and dietician where there was a risk associated with nutritional intake.

People told us the service supported them to be healthy. They said staff helped them access health care professionals. One person told us, "Staff arrange appointments for me." We noted that one person attended

Is the service effective?

a medical appointment on the day of our inspection. Records showed that people had access to health care professionals including opticians, dentists and podiatrists. We saw people had an annual medication review via their GP and a Care Program Approach (CPA) review for medication for mental health. The CPA is a national system which sets out how mental health services should help people with mental illnesses and complex needs.

Through discussions with staff and examining care plans we found that staff had a good understanding of the mental health needs of people who used the service. For example, care plans indicated that the service focussed on understanding the behaviours and needs of people in relation to their mental health and supporting them with these. This meant the service was focused on meeting health care needs in a personalised manner.

Is the service caring?

Our findings

The registered manager told us they believed the service had enough staff to meet people's basic needs but told us more staff would help to meet other needs. For example, the registered manager said staff did not always have enough time to work with people to help develop their independent living skills. The registered manager told us that staffing levels had increased since our previous inspection with the introduction of 15 hours of extra staff cover a week to provide activities. The manager spoke with us after the day of our inspection and told us it had been agreed that a further 22 additional staff hours would be provided per week.

We saw that during part of the day between 2pm and 9:30pm only two staff were on duty to support 18 people. The registered manager told us this was the assessed staffing levels for that time. We saw staff were busy with tasks such as medication, paperwork and supporting people with drinks and snacks. We observed a bingo session run by staff. People were seen to be engaged in this and enjoying it. However, other than the bingo there was very little interaction with people. People were sitting around with little stimulation or attention from staff. This meant they had only limited opportunity to engage in meaningful activities with staff.

People told us they were treated well by staff. One person said, "Staff are not rude here, they are very polite." Another person said, "I like this place, friendly people (staff)." People told us they were able to make choices about their daily lives and their independence was supported. One person told us, "I choose what I wear" and "I went to the hairdressers myself."

We found that the service sought to meet people's needs with regard to equality and diversity. For example, people were able to cook food that reflected their culture. People showed us their bedrooms and we saw they were decorated with items of cultural and religious significance. We noted in one bedroom that the television was tuned to a station broadcasting in the preferred language of the person. Staff told us they supported people to attend places of worship and one staff said they were organising for a person to join a community centre for people of his ethnicity.

Staff had a good understanding of how to promote people's dignity. One member of staff told us they asked people what they wanted, providing people with choices. Staff said they supported people to manage as much of their own care as possible to promote their independence and promoted people's privacy by making sure curtains and windows were closed when providing personal care. We noted that each person had their own bedroom which afforded them a degree of privacy. The registered manager said one of the strengths of the service was that it was caring and treated people with dignity and respect and people were happy.

Although interaction between staff and people who used the service was limited due to the low numbers of staff working, the interactions we did witness were caring and sensitive on the part of staff. We saw staff to be polite and friendly and people appeared relaxed and at ease in the presence of staff. Some people expressed a wish to be left alone and we saw that staff respected this.

Staff told us all the people who lived at the service understood spoken English but one person could not speak it themselves. They said they offered this person a choice and they were able to indicate what they preferred. Care plans included information about how to meet people's communication needs. For instance one plan indicated that the person could speak on the telephone but needed a member of staff close at hand in case there was anything said they did not understand.

All care plans we reviewed included an End of Life document which outlined any preferences the person had regarding funeral arrangements, type of service preferred and who to contact. This demonstrated people being actively being involved in decision making. However, we noted the End of Life document for one person stated their end of life arrangements to be carried out in line with their faith but gave particular details which were inconsistent with the belief of that faith. We discussed this matter with the registered manager who told us they would consult with the person and their family and revise the plan if necessary.

Is the service responsive?

Our findings

Care plans included a 'Key Information Sheet.' This was a very condensed version of the overall plan that included important information such as the person's relapse indicators and what actions could help in the event of a relapse. This document was useful for agency staff who worked only one shift at the home as it enabled them to understand a person's key requirements relating to their health and safety when the staff did not have time to read people's full care plan.

Care plans included basic information for example about how to support people with personal care and also included information about how to support people to achieve goals and what was important to them. For example, one person's care plan said the most important thing in their life was maintaining good relationships with their family members and there was information about how to achieve this. This showed care plans reflected people's wishes. We saw that some people had not only been involved in developing their care plans but had typed them as well. This was a good example of people having involvement in their care.

People had a designated key worker with whom they had regular one to one meetings. This gave them the opportunity of discussing how progress could be made with regard to their identified goals in their care plans. Records confirmed these meetings and evidenced discussions about matters of importance to the person. We found that care plans were reviewed every six months or more frequently if required. This meant they were able to reflect people's needs as they changed over time.

Staff had a good understanding of people's individual needs. One member of staff told us they had worked at the service for three years. This had given them the opportunity to work closely with people and get to know them and build trusting relationships with people. Staff gave examples of how they responded to individual needs. For example, they said some people became anxious when in large groups outside of the home so they always supported them to go out of the home without any other people. This meant staff responded to the individual needs of people.

The registered manager told us they were in the process of introducing a system to match staff skills and interests with those of people that used the service. This involved

assessing staff members to find out what particular skills and interests they had so they could then work with people who shared those interests. For example, it was identified that one member of staff had an interest in sewing as did a person that used the service, so they were able to do this activity together.

The registered manager told us they believed the service had enough staff to meet people's basic needs but told us more staff were needed to meet other needs. For example, the registered manager said staff did not have enough time to work with people to help develop their independent living skills. The registered manager told us they had raised the issue of staffing levels with their manager on "numerous occasions" but had always been told there was no budget to provide any extra staff.

We saw that during part of the day between 2pm and 9:30pm only two staff were on duty to support 18 people. The registered manager told us this was the assessed staffing levels for that time. We saw staff were busy with tasks such as medication, paperwork and supporting people with drinks and snacks. However, other than a planned activity of bingo we saw very little interaction between people and staff. People were sitting around with little stimulation or attention from staff. This meant they had only limited opportunity to engage in meaningful activities with staff.

People told us they knew how to make complaints. One said, "I would go to the manager if I had any issues. She is helpful." Another person told us, "They say at every meeting if we have a complaint we can take it to East Thames (the provider)." The service had a complaints procedure and a copy of this was on display within the service. The procedure included timescales for responding to complaints. However, it included incorrect information about who people could complain to if they were not satisfied with the response from the service. We discussed this with the registered manager who said they would raise this issue with the provider.

We saw that complaints received were recorded and investigated, and were possible resolved to the satisfaction of the complainant. For example, we saw one person complained because they were not able to look after their own money. After carrying out a risk assessment it was agreed that the person was able to look after their own money. This showed changes and improvements were made as a result of complaints.

Is the service well-led?

Our findings

The service had a registered manager in place and a clear management structure. The registered manager was supported by two deputy managers and each shift had a designated person in charge. This meant there was always a member of staff accountable to make any decisions that needed to be made during a shift.

People said they found the manager to be helpful. One person told us, "I think she (the registered manager) is pleasant and comfortable to get on with. She is approachable." Staff agreed that the registered manager was approachable and told us they could discuss issues with senior staff as needed. Comments included, "Managers will always make time" and "She (registered manager) is happy to talk about things with us." We observed that people were able to come into the office and talk with managers throughout the course of our inspection. This demonstrated that managers made themselves available to people that used the service.

There were opportunities for relevant persons to be involved with the running of the service and the service had various quality assurance and monitoring processes to help drive continuous improvement. Staff told us that in addition to regular supervision meetings they also attended staff meetings. Records showed staff were able to discuss the needs of individual people at these meetings and share ideas about how best to support people. Staff told us they were in the process of completing a survey for the provider. This had only recently been issued and the provider was still in the process of receiving completed surveys at the time of our inspection.

The registered manager told us that a survey had been undertaken of people that used the service to gain their views on what the service was doing well and areas that could be improved upon. The registered manager told us this survey was carried out annually and that the most recent one was in August 2014. They told us they had not

analysed the results or produced an action plan at the time of our visit. We viewed some of the completed survey forms which contained mostly positive feedback about the service.

People told us they had 'residents meetings' where they could discuss issues of importance to them. One person said, "It got brought up about vegetarian food at the meeting because I am vegetarian." Another person told us, "We can talk about if anything is broken and it is usually repaired within 24 hours." This indicated that 'residents meetings' were an effective mechanism for people to effect improvements. We saw minutes of residents meetings. Some agenda items were led by people that used the service such as activities and other by staff. For example, at a recent meeting staff explained to people their right to make a complaint and how to do so if they so wished.

In addition to seeking views of people that used the service other systems were in place to promote quality in the service. A senior manager from the provider who did not work at this location carried out a monthly visit to the service. This highlighted shortfalls that were then addressed. An annual health and safety audit were carried out of the premises and staff carried out a three monthly health and safety check of people's bedrooms.

Various audits were carried out. We saw records of audits of care plans and medication records. The registered manager told us any areas of concern identified through these audits were addressed with the relevant staff member. The registered manager told us that the quality assurance processes in the service had led to improvements. For example, the introduction of an easy read version of the complaints procedure was in response to a shortfall identified through quality assurance processes. However, audits had failed to identify issues of concern relating to the recording and administration of medicines and poor recording with regard to people's capacity assessments. These showed audits were not sufficiently robust to identify shortfalls within the service.

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 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	<p>Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines</p> <p>The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity. Regulation 13.</p>