Striving for Independence Homes LLP

College Road Care Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 9 March 2014 and was unannounced.

College Road Care Home provides accommodation and personal care for a maximum of three people with learning disabilities. There were two people using the service on the day of our inspection. At our last inspection in October 2013 the service was compliant with all the regulations we looked at.

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 and associated Regulations about how the service is run.

Although people's records showed that they had access to healthcare professionals, the provider did not always ensure people received coordinated care with other services involved in people's care.

Summary of findings

Care plans and risk assessments were not always updated following reviews or when there was a change in people's needs. This meant staff did not always have an accurate care plan record to ensure they had information about how to meet the person's individual care needs.

Senior management and staff were aware of the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, the care files did not have adequate assessments of people's mental capacity to make decisions about their care or treatment. In addition, there was not an effective system in place to prevent people being unnecessarily deprived of their liberty. For example, the provider had not made an application under DoLS for people living at the home, even though their liberty may have been restricted.

There were limited systems in place for staff to discuss issues and influence the operation of the home. The provider did not have regular meetings with people, relatives and staff, including surveys to gather their views about the quality of the service.

The provider did not have a robust recruitment policy that covered employing ex-offenders. There was no guidance to follow in relation to managing job applications involving ex-offenders. This meant that people could be at potential risk of receiving care from staff that may be unsuitable to work with vulnerable adults.

The provider did not have an effective process of monitoring quality. We found that the provider had not picked up on risks to people's safety and welfare that we had identified during our visit.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

The provider did not ensure the recruitment practices always ensured people were protected from staff unsuitable to work with vulnerable people. This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider did not have suitable arrangements in place for obtaining, and acting with, the consent of service users in relation to the care and treatment provided for them. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered person did not have suitable arrangements to ensure staff were appropriately supported by receiving supervision and appraisal. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered person had not taken proper steps to ensure that each person was protected against the risks of receiving inappropriate care and treatment because the provider did not always plan and deliver the service in a way to meet individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered person had not protected people against the risks of inappropriate or unsafe care by means of the effective operation of systems to assess and monitor the quality of services provided. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also made recommendations in relation to coordination of care between services, people's involvement in their care, meeting people's communication needs and in respect of supporting people when they wanted to make complains about care.

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

Some aspects of the service were not safe. Medicines were not appropriately managed. There were no systems in place for regularly auditing the safe management of medicines

The provider did not follow robust recruitment procedures before staff began to work at the home. This meant that people were at potential risk of receiving care from staff that may be unsuitable to work with vulnerable adults.

The service had a safeguarding adult's procedure in place. Staff knew how to recognise signs of potential abuse and the relevant reporting procedures.

Is the service effective?

Requires improvement

Some aspects of the service were not effective. Care plans were not detailed and did not always reflect people's changing needs.

People with healthcare needs were not always monitored to ensure they received appropriate care. The provider did not ensure appointments with healthcare professionals were followed up on.

The provider did not ensure proper steps were taken so that decisions were made in people's best interests, where people could not consent to their care.

Is the service caring?

Requires improvement

Some aspects of the service were not caring. The provider had not developed a range of methods in order to meet people's communication needs.

The provider did not regularly involve people and their relatives were in care. This meant people's views and experiences were not always taken into account in the way the service was provided and delivered.

Staff were kind and compassionate. They treated people with dignity and respect. The staff took time to speak with people and to engage positively with them. This supported people's wellbeing.

Is the service responsive?

Requires improvement

Some aspects of the service were not responsive. Some people's needs had not been thoroughly and appropriately assessed. Their changing needs were not always reflected in their care plan, which meant they did not always receive support in the way they needed it.

People and their representatives were not involved in planning, reviewing and updating care plans

People's choices about their activities were supported. People were provided with a range of activities.

Summary of findings

Is the service well-led?

The service was not well-led. The provider did not promote a transparent culture, which ensured people using the service; staff and people's relatives were included and consulted about the way the service was run.

Staff did not receive regular supervision and appraisals. The provider did not carry out regular staff meetings.

The provider did not have robust quality assurance processes to ensure the quality of the service was under constant review.

Inadequate

College Road Care Home

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 was carried out by one inspector. During the inspection we spoke with two staff members, the registered manager and the service director. We were not able to speak with people using the service because they had complex needs and were not able to verbally share their experiences of using the service with us. We gathered evidence of people's experiences of the service by reviewing their care records, observing care and talking to their relatives. We looked at two care records of people receiving care and seven staff records which included recruitment information.

Some people had complex needs so we used the Short Observational Framework for Inspection (SOFI) to observe the way they were cared for and supported. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires improvement

Is the service safe?

Our findings

People who lived in the home were not safe because some aspects of recruitment process were not robust. There was no policy for responding to applications from ex-offenders. We saw that one staff member with criminal convictions had been employed, without carrying out a risk assessment to make sure they were suitable to carry out their duties without presenting a risk to people. Although senior management told us they had considered the offences and weighed up the risks, there was no evidence this had been carried out. In addition, senior management could not locate a criminal record check for another staff member. The provider phoned us after the inspection to inform us they had located the criminal record check for this individual. This showed there was a lack of a consistent audit trail for all the checks completed or pending for new staff. This meant that people could be at potential risk of receiving care from staff that may be unsuitable to work with them.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the medicines management of the service. People's current medicines were recorded on the Medicines Administration Records (MAR). There were no omissions in recording administration and when we checked stocks of medicines all counts tallied and we were able to confirm medicines had been given as prescribed. However, we found some inconsistencies in the codes used when recording medicines, which were administered to be people when they were at the day centre. The codes had been used inappropriately to indicate medicines that were given at the day centre. This did not correspond with the codes on the MAR sheet and was not defined on the reverse of the MAR sheet. Senior management said this would be addressed immediately following the inspection.

Staff said there were sufficient numbers of staff on duty to provide safe and effective care. The management team told us staffing levels was informed by people's dependency levels. There was an on-call system, which ensured there was always a senior manager at hand to provide advice for any matters of concern. On occasion, bank staff from the provider's other two services were used to provide cover for some shifts in case of staff absence. This meant that people were supported by staff that were familiar to them.

There was a safeguarding adult's procedure in place. Staff knew how to recognise signs of potential abuse and the relevant reporting procedures. They were also aware of the whistleblowing policy and who they could contact to raise whistleblowing concerns. They were aware that they could report allegations of abuse to the local authority safeguarding department and the Care Quality Commission (CQC) if their manager did not take appropriate action to abuse allegations. Staff had attended training on safeguarding adults so that their knowledge was up to date.

Risk assessments had been completed for each person along with a risk management plan to minimise identified risks. Staff said they read people's care plans and risk assessments before delivering care so that they were fully aware of individual needs and potential risks to their health and safety. Staff had a good understanding of how to support people who exhibited behaviours that challenged the service. They described techniques they employed to calm people who were showing signs of agitation or anxiety. In one example, we observed staff reassuring one person, who was getting anxious because of change of routine. This helped to resolve the situation and the person soon was calm and settled.

We viewed a sample of equipment servicing and maintenance records. These showed that equipment such as gas appliances, and the fire alarm and emergency lighting systems had been checked and maintained at the required intervals, to ensure these were safe.

Requires improvement

Is the service effective?

Our findings

We observed people were looked after by staff who were kind and caring. However staff did not receive the level of support they required to effectively meet people's needs.

Staff files did not include information in relation to their induction. The staff files we checked did not show how their competence to carry out their duties was checked following the completion of their induction. Even though staff told us that they felt supported by senior management, their records did not demonstrate they were appropriately supported in their roles through regular supervision and appraisal. There was no consistent record of the supervision they had received. The provider's policy stated, 'care staff to receive formal supervision at least six times a year' and that 'supervision meetings are recorded' but this was not being carried out. This meant staff were not adequately supported by the management team to carry out their roles effectively

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not always sought the consent of people to their care and treatment in line with Mental Capacity Act 2005 (MCA). MCA is legislation to protect people who are unable to make decisions for themselves. The framework ensures decisions are made in people's best interests. We saw that people living at the home needed support to make day to day decisions around their care and also lacked the mental capacity to make some decisions. However, there was no evidence that people's capacity to consent to care and treatment had been assessed. There were no specific assessments for individuals in respect of making a particular decision, for example in treatment and accessing the community for activities.

At this inspection senior managers told us there were no Deprivation of Liberty Safeguard (DoLS) authorisations in place and no applications had been submitted for people currently using the service. The DoLS are there to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. Services should only deprive someone of their liberty when it is in the best interests of the person and there is no other way to look after them, and it should be done in a safe and correct way. We identified that people using the service needed to be considered for a Deprivation of Liberty Safeguards Authorisation because they were subject to continuous supervision by staff, and could not freely go outside without staff because of safety concerns. The provider may have been depriving the people of their liberty without the necessary authorisation to do so.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's records showed that they had access to healthcare professionals such as GPs, dentists and opticians when they needed to. We saw evidence in records that, when people's needs changed, appropriate referrals were made immediately to relevant community health professionals. However, in one example we saw that the provider had not ensured one person received coordinated care with other services involved in their care. This person had not received support to attend a medical appointment. The purpose of the appointment was to review this person's progress after an earlier diagnosis in order to inform on-going treatment. We saw from the letter that the provider received that the person had not attended this appointment. In the end, this person was discharged as an outpatient for failing to attend the appointment. When we spoke with senior management, they were not aware that this person had not been supported to attend the medical appointment. This person was at risk of receiving inappropriate care if they continued to receive care that was not coordinated.

Staff told us that people were asked what they wanted to eat, from the choices available, before meals were prepared. There was a stock of fresh foods available to prepare the meals from, which helped provide people with nutritious food. People had drinks easily available. These were regularly replenished, and people were encouraged and supported with fluid intake.

The training completed by staff was recorded in staff files. This showed staff had received on-line training covering a range of topics including, dignity and respect, equality and diversity, infection control, managing challenging behaviour and MCA 2005.

Requires improvement

Is the service effective?

We recommend that the provider examines relevant guidance and its care coordination activities to ensure people's care and information sharing is improved among all providers involved in people's care.

Requires improvement

Is the service caring?

Our findings

The interactions between staff and people were caring and respectful. People walked freely and comfortably around their own home. Staff had relevant knowledge regarding people's routines, and their likes and dislikes.

People's dignity and privacy was respected. Staff told us they supported people to manage as much of their own care as possible to promote their independence. They said they promoted people's privacy by making sure curtains and windows were closed when providing personal care. We saw that each person had their own bedroom which afforded them privacy. When support was required, people were attended to in a timely manner. We saw that staff frequently reassured a person who became unsettled because of change in routine. This was done in a patient, kind and compassionate way, which had a calming effect.

Staff were polite and friendly and people were relaxed in the presence of staff. Staff acknowledged people as they walked into the sitting room and spent time talking to them. Staff made the time to talk with people and explained things to them. We observed staff were calm and confident in carrying out their roles. They noticed if someone was distressed and gave reassurance and comfort.

Staff had knowledge of the people they cared for. They were able to tell us about people's personal histories and interests. Care plans included information about people's likes and dislikes such as their preferred daily routines. However, staff did not always update the care plans of people in light of their changing needs.

The provider did not regularly evaluate how people and their relatives were involved in care. For example, one person had a family but we did not see evidence from care records of their involvement; either in care planning or care reviews. The other person did not have a family; however the provider had not sought to refer this person to advocacy services, until recently. This person has lived at this home for a number of years. This meant people did not have their views and experiences taken into account in the way the service was provided and delivered.

We recommend that the provider reviews relevant policies on person centred care, to inform improvement in involving people in their care.

Requires improvement

Is the service responsive?

Our findings

People's individual records showed that a pre-admission assessment had been carried out before they moved to the service. Assessments of need were in people's files and the information was used to develop people's care plans. Care plans included details on the person's individual needs and how staff should provide care and treatment. However, one person's care plan did not adequately guide staff so that they could meet this person's needs effectively. This person's care plan had not been changed to reflect changes in their care following a medical diagnosis, which required that their diet was changed to prevent further deterioration. The provider was given dietary advice by healthcare professionals but the care plan and dietary requirements of this person had not been updated in light of the changes to their needs. This meant staff did not have an accurate care plan record to ensure they had information about how to meet this person's needs. This put the person at risk of being provided with inappropriate or unsafe care.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us all the people who lived at the service understood spoken English but one person was deaf and was not verbal. The care plan of this person included information about how to meet their communication needs. The care plan stated, "I like to use symbols and pictures to make people understand me", "Show me pictures to make me understand what you ask me" and other instructions to facilitate communication. However, staff were not using pictures, symbols and objects to facilitate communication with this person, which meant their communication needs were not being met.

Senior management told us they held regular meetings with people who used the service in order to get their views on the service provided. However, these meetings were not always recorded and when they were recorded, we did not see evidence that they fed into people's care plans. This meant there was not always a clear record of people's views and agreed actions. Senior management told us they were making improvements to their recording systems. At this inspection we observed that there was work in progress to transfer people's personal information and updated care plans to an electronic system, in order to improve the management of care records.

Staff told us how they supported people with activities. People's care records showed there were arrangements in place to meet their social and recreational needs. People were asked for activity preferences, and we saw this was recorded in people's care files. People attended a day centre for social activities.

The provider did not ensure people using the service and their relatives were always encouraged to share their views about the service. The complaints procedure was not accessible to people using the service and their relatives or representatives. The procedure was not displayed where people using the service and their relatives could see.

We recommend that the provider take action in regards to meeting the communication needs of people they support and explore how to overcome communication barriers.

We also recommend that the provider review relevant literature regarding how to encourage people with learning disabilities to complain when they experience poor care.

Inadequate

Is the service well-led?

Our findings

Although there were systems to assess the quality of the service provided in the home, we found that there was no leadership to ensure these were effectively implemented. The systems had not ensured that people were always protected against inappropriate or unsafe care and support. We found that the provider had not picked up on risks to people's safety and welfare that we had identified during our visit. An effective quality monitoring process could have helped the provider identify and address identified shortfalls.

Staff were not aware of the organisational values or how the service planned to develop. People living at the home, their representatives and staff were not consulted about service developments. Senior management told us people were consulted but records of this could not be located. There was no analysis of concerns or feedback from people living at the home. The provider did not have an accident and incident book. Therefore people living at the home could not be confident that the provider had taken the necessary steps to protect them from the risks of unsafe and unsuitable care and treatment because systems to monitor the quality of the service were inadequate.

Staff spoke positively about the senior management and felt supported by them. They felt able to raise any concerns and complaints and they were confident that these would be actioned. However, we found there were no effective systems in place for staff to discuss issues and influence the operation of the home. We found that staff meetings, supervision and appraisals were not held regularly.

There were not consistent mechanisms in place for seeking people's views and that of their relatives about the running of the service. There were no completed surveys, analysis of results or action plan produced regarding how to respond to the survey. In addition, the service did not issue surveys to other relevant stakeholders such as relatives, staff and health and social care professionals. This meant the service was not able to learn and develop from the views of stakeholders or provide a service more responsive to the needs of the individuals.

All the issues above meant there was a lack of systems in place to check that people's needs were being met and that the service was operating effectively. The provider had also not identified the shortfalls we found during this inspection.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The registered person did not always operate effective recruitment procedures in order to ensure people employed were of good character and had the skills and experience which are necessary for the work to be performed.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person did not have suitable arrangements to ensure that persons employed were appropriately supported by receiving appropriate training, professional development, supervision or appraisal.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered person did not have suitable arrangements in place for obtaining, and acting with, the consent of service users in relation to the care and treatment provided for them.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person had not taken proper steps to ensure that each person was protected against the risks**

This section is primarily information for the provider

Action we have told the provider to take

of receiving inappropriate care and treatment because they had not carried out an assessment of all the needs of people and did not always plan and deliver the service in a way to meet individual needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity; and regularly seek the views (including the descriptions of their experiences of care and treatment) of service users, persons acting on their behalf and persons who are employed for the purposes of the carrying on of the regulated activity, to enable the registered person to come to an informed view in relation to the standard of care and treatment provided to service users.