Care Quality Commission

Caretech Community Services (No.2) Limited

Westbrook House

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

Overall summary

The inspection was carried out on 10 February 2015 and was unannounced. At our previous inspection in February 2014 the service was found to be meeting the required standards.

Westbrook House is a care home which provides accommodation and personal care for up to eight people with learning and physical disabilities. At the time of our inspection there were eight people living at the home. There was a registered manager in post. 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. However, the registered manager was not responsible for the day to day running of the service.

Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At

Summary of findings

the time of the inspection applications had been made to the local authority in relation to people who lived at the service and were pending an outcome. The manager and staff were familiar with their role in relation to MCA and DoLS.

People did not always have their individual needs met in timely manner due to routines set up in relation to continence care. Personal care was personalised in regards to how it was carried out but restriction on times meant that it was sometimes task orientated.

Recent staffing changes had impacted on the standard of care provided and this was being worked on to improve the service through on going recruitment. The staff at the home had developed a folder to advise new staff and agency staff of people's care and support needs.

People's relatives and staff told us that staffing levels meant that people did not always have their social needs met. This was in relation to activities outside the home and supporting hobbies and interests while at the home. This significantly affected people who did not access day centres.

People had not had their ability to make decisions assessed and therefore best interest decisions were not documented, or who was able to make decisions on their behalf. The service had started to work with the local authority to rectify this.

Medicines were managed safely. Staff were clear on how to promote health and safety within the home. However, we found that some staff had not received any training and for others the training was out of date. This had been identified by the deputy manager. Staff supervisions were also out of date but were being started by the deputy managers.

People's nutritional and healthcare needs were met. Care plans required updating, however, staff were aware of people's specific needs and health conditions. The deputy managers were working on updating care plans.

The management in the home was unstable and this had meant systems to monitor and manage the quality of the service were not properly used and areas for improvement had not been identified or resolved.

At this inspection we found the service to be in breach of Regulation 9, 10, 11, 18, 19, 22 and 23 of the Health and Social care Act 2008 (Regulated activities) Regulations 2010, which corresponds to regulations 9, 11,13, 16, 17, 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People were unable to tell us if they felt safe at the home due to their complex needs.

Staff were not aware how to report an allegation of abuse.

People's needs were not always met due to low staffing numbers and changes to the staff team.

Medicines were managed safely.

Requires improvement

Is the service effective?
The service was not effective.

People did not have their ability to make decisions assessed.

Staff did not always receive the appropriate training and supervision for their role.

People's nutritional needs were met and there was access to health care professionals.

Requires improvement

Is the service caring?
The service was caring.

Staff were committed to developing good relationships with people.

People's privacy and dignity was respected.

People or their relatives were involved in planning their care where possible.

Good

Is the service responsive?
The service was not responsive.

People's care was not always met in a way that met individual needs.

People had limited opportunities for activities and access to outside interests.

Requires improvement

Is the service well-led?
The service was not well led.

There was a lack of effective leadership and direction.

Quality assurance systems were not consistent or effective.

Requires improvement

Westbrook House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012 and to look at the overall quality of the service.

This visit was carried out by two inspectors on 10 February 2015 and was unannounced.

Before our inspection we reviewed information we held about the service including statutory notifications and enquiries relating to the service. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with three relatives, four members of care staff, a housekeeper, a driver, deputy manager and had contact with the registered manager. We received feedback from health and social care professionals. We viewed three people's support plans. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to complex health needs.

Requires improvement

Is the service safe?

Our findings

People were unable to tell us if they felt safe. Relatives told us they felt there were issues relating to management which affected people's safety. For example, issues with equipment and staffing changes. One relative told us, "[Relative] is safe at the home."

However, staff did not have the appropriate knowledge of how to report an allegation of abuse or a safeguarding issue. They told us that they would immediately report concerns to their line manager however, they did not demonstrate an understanding of reporting outside the service. For example, directly to the commissioning authority. This was despite a copy of the Hertfordshire county council safeguarding policy and procedure available on the notice board in the home. The deputy manager was clear on how to report any areas of concern both internally and externally. One staff member said they may contact the CQC but did not know how to find the contact details. This meant that due to the unstable management structure at the service, there was a risk that there may be a delay in reporting an allegation of abuse.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us that there were not enough staff available to ensure that people's social needs were met. Staff told us that an increase in staffing levels would improve the lives of the people who used the service. For example, people who did not have the benefit of going to the day centre would have more opportunity to go out into the community if there were more staff available to support this. Staff told us that they did not always have time to provide activities for people as they were providing care and support. They told us that additional staffing would enable them to take people out and do more with them. Staff said that all eight people who used the service needed two staff members to support them with their personal care. This meant that people's personal care was delayed when there were four staff on duty in the morning and one person needed to administer the medications. In addition, a healthcare professional told us that staffing issues had impacted on people's social welfare as attendance at day centres and activities had sometimes been cancelled due to low staff numbers.

This was a breach of Regulation 22 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.

People's care delivery was assessed for areas of risk in order to promote their health, safety and well-being. These included such keeping people safe through the night, use of the tail lift vehicle, falling from bed and use of bed rails, using public transport, using the bath, use of lap belts to keep people safe in a wheelchair, and using slings and hoists to transfer. These risk assessments were reviewed six monthly to ensure they continued to keep people safe.

Newly recruited staff told us about the recruitment practices undertaken before they started to work at the service. These included a written application form and face-to-face interviews with management. All staff members told us that they were not able to start work at the service until satisfactory references and criminal record checks had been completed.

People did not have the capacity to manage their own medicines and were supported to take their medicines by staff. Medicines were recorded, stored and managed safely. There was clear information about each person's individual health needs and the support they required to ensure they received their medicines safely. Staff told us that they did not administer medications until they had received the training to do so. We saw that training had been provided. This meant that people received their medicines in accordance with the prescriber's instructions and in a way that promoted their welfare.

Requires improvement

Is the service effective?

Our findings

People were unable to tell us their views of how staff supported them. Our observations of staff supporting people were positive in that staff knew people well and knew their needs. However, although established staff members told us that they had received training in such areas as moving and handling, first aid, safeguarding and infection control, newly recruited staff had not received any basic core training since they started with the service in December 2014. The manager and deputy manager told us training had been booked.

People were at risk of receiving care that was inappropriate or unsafe. Staff did not all have the relevant knowledge to support the people they cared for and had not received training in these areas. For example, staff were not clear on how to safeguard people from the risk of abuse, pressure care or nutritional care. All except one staff member told us that they had not received one to one supervision for a long period of time and newly recruited staff told us that they had not received any one-to-one supervision since they started to work at the home in December 2014. Therefore gaps in training and knowledge had not been identified. This meant that although staff displayed some skills to support them in their role, due to a delay in training and supervision there was a risk of staff providing support outside of current guidelines.

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.

People had not had their ability to make decisions assessed. We saw that people's lifestyle choices had been recorded in their care plans so for those who were unable to express choice staff had some guidance to follow. We observed staff supporting people with those choices. For example, how they spent their time. We were told by the deputy manager that people were yet to have a formal mental capacity assessment and therefore best interest decisions were not documented. They told us that contact had been made with the commissioning authority to have this carried out for people. We were also told that there were no DoLS authorisations in place and that applications were underway in regards to people with bedrails, lap belts and going out alone. However, the delay in the correct procedure being followed in relation to the Mental Capacity Act 2005 (MCA) meant that there was a risk that people may have received care or support that they had not consented to.

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 were supported to eat and drink sufficient amounts. We saw people being supported to eat and drink in a way that met their individual needs. For example, where a person refused to eat their lunch in the usual way, staff followed guidance from a dietician about the consistency of the food and being given it in a cup so they could then drink it. Staff were available to support people to eat and when small amounts were eaten, this was communicated through the team so that alternatives could be offered. We saw that supplements were available and also thickening powder to help people with swallowing difficulties. Some people received food and drink through a tube and staff were knowledgeable about this .There was clear guidance on how to support people. For example, the record explained that the person could not eat food and received their diet via a tube into the stomach. There was good detail, which included the times of the start of the feed and how much liquid food to be delivered. We saw that people's weights until recently had not been monitored regularly.The deputy manager had now set up a time table to ensure people were weighed monthly or weekly if they were a higher risk of malnutrition. Food and fluid intake was monitored and when there was a concern, staff contacted the GP, dietician or Speech and Language therapist.

Various health professionals had been involved with people's care. These included learning disability nurses, opticians and GPs. Information about people's demeanour and well being was handed over from one shift to another. For example, to ensure that the dietician was contacted for a person or to contact the district nurse when needed. Health care professionals were positive about staff and how they supported people with their needs. However, professionals told us that staff had people's best interests

Requires improvement

Is the service effective?

at heart but due to staffing issues were unable to consistently follow their guidance in regards to peoples' mental health. For example, the ability to provide intervention plans to provide structure for a person.

Good

Is the service caring?

Our findings

People responded to staff when they communicated with them through speech, touch, facial expression or body language. Although people we observed were unable to verbally communicate, we saw that they welcomed the staff's approach. For example, smiling, turning their head, or calling out when the staff left them. Staff responded to these non-verbal communications in a way that showed they knew people well. For example, supporting someone to drink independently, even though they may have spilt some of it. We heard them saying, "I know you like to do it yourself." The person did drink independently with an apron to protect their clothes which was promptly changed when they had finished. This was done in a way that was respectful and respected their dignity.

People's privacy was promoted. Doors were closed when people received care and staff told us they kept them covered as much as possible during personal care. We heard staff discussing about the appropriateness of a male carer supporting a female resident and it was organised so that a female staff member could support them.

Staff had access to clear guidance to enable them to communicate effectively with people. This information was easily accessible and written in a way that new or agency staff could read and memorise before supporting a person. For example, one person's records asked staff to be patient and allow a person to repeat themselves. It also stated that they did not have a wide vocabulary so the better staff grew to know them the better they would understand what they was saying. The care plans described how people would communicate their needs and staff were encouraged to get to know people well so that they could react appropriately. We saw staff listen, watch and understand what people were communicating. For example, when a person didn't want to be alone, another who wanted a coffee and when someone expressed they did not want to join in with the activity. We noted that two of the staff were relatively new but they had already developed a positive relationship with the people they were supporting. For example, there was banter and warmth which people responded to.

Relatives of people told us that the staff were caring. One relative said, "The staff are always very caring. I am quite happy with how [relative] is cared for at Westbrook House and [relative] is happy there." Another relative told us, "People who do the hands on care are really lovely and they do a really great job." Our observations on the day of inspection supported these comments.

People were not able to be actively involved in planning their care and involvement from relatives was not always recorded. However, care plans did include people's likes, dislikes and preferences. One relative told us, "The communication is not great, we do not have any idea what is going on." The deputy manager acknowledged that recent staffing issues had negatively impacted on involving people and their relatives in planning their care. However, they were working on new care plans which they said would involve people. The manager told us, "I have 1:1 meetings which I hold when families request."

Requires improvement

Is the service responsive?

Our findings

The service recorded compliments received and had a log of environmental complaints which had been investigated and resolved but there were no recorded complaints in relation to care provision. One relative told us, I have never had a word bad to say about the home, I haven't got any complaints." However, two relatives told us that they had cause to make complaints about the service over the past year. They had raised concerns verbally with management. The manager told us that there had been no formal complaints and they had responded to people's concerns informally. They said, "There has been active management of family member support and not escalated as official complaints. I have email correspondence between myself and family members." We found that there was inconsistency in how complaints were managed. Relatives felt their issues were not resolved effectively and they were not always taken seriously.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives had mixed experiences about the care people received. One relative told us, "I think they are meeting her needs. I am quite happy with how [they are] cared for at Westbrook House." Another person told us that their relative was not having their care needs met. They said, "[They are] often wet when we go into see [them]. [Their] mobility has greatly reduced since [they have] been there."

On the day of our inspection people's personal care needs were being met. However, we did note that people were not taken to the toilet at individual times. Staff told us that every four to six hours they take people to change their continence products on their beds. This meant that people may be sitting for extended periods of time in wet or soiled clothing as they were being given support on a scheduled basis rather than in an acceptable, personalised timeframe. Therefore people were at risk of not having their needs met in a timely fashion and this increased the risk of people developing pressure ulcers.

There were no meaningful or stimulating activities provided for people on the day of the inspection. Some people went out to the day centre but there was nothing planned for people who stayed at the home, some of whom never visited a day centre. People's care plans detailed activities they enjoyed doing such as puzzles, playing cards, reading catalogues, cats, having nails painted, helping in the kitchen. We saw staff try to engage two people in a game of bowling, one person joined in with support from staff but the other was not interested. No additional activities were offered. One person was content colouring in a picture, however, their family told us that it is the only activity that the person did. The relative said, "[Their] face really lights up when [they] have some social stimulation such as going to the pub but this does not happen anymore. [They] used to enjoy going to church but this also does not happen anymore." The relatives felt that the person was at risk from social isolation. We saw visits to the pub requested in resident meetings. The staff told us that this had not yet started. Staff told us that they did not always have time to provide support with hobbies and interests or provide stimulating activities.

Relatives told us that the activities provided were insufficient to meet people's needs. One relative said , "Lack of activities and social stimulation. Lack of initiative and lack of resourcefulness. Monday, Tuesday and Wednesday, [staff member] works and [they] are really good with people. [They] play with people, puts [the internet] on and sings with people." Another said, "[They} don't get out as much as we would like them to. We asked for their church attendance to be kept up but it is now apparent that this does not seem to happen. I liken it to institutionalised care. I am not sure that [their] social needs are being met."

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.

There were a number of agency staff that had worked at the home to provide cover during a period of high staff turnover. A 'grab folder' had been developed to provide up to date 'at a glance' information to support the agency staff and staff new to the service to provide person centred care. We saw that this folder contained detailed instructions for staff to follow in such areas as providing personal care, supporting people to eat safely, communicating with people, their preferred diet and likes and dislikes.

Staff had a good understanding of people's needs and were able to describe how they supported people. We observed

Requires improvement

Is the service responsive?

people being assisted in a way that was recorded in their grab file. Staff were aware of the grab files and the reason they were in place. Care plans were currently being updated. The deputy manager told us they were out of date and they were working through them. However, the information in place was detailed and individualised. For example, "I like to go to bed early around 7 PM. I will ask you when I wish to go to bed. I like to wear a full length nightdress and hand knitted bed socks (hand knitted by my [relative])." This element of the care plan described in detail the support that this person needed to settle for the night.

Resident and relative meetings were held regularly. We saw from a recent meeting that a person had requested a cat for the home. Staff had recorded people's non-verbal reaction to this to acknowledge their feedback. For example, when a person had smiled and clapped at the idea of having a cat in the house. We saw that a cat had been added to the house and staff told us people enjoyed it. Notes from a recent relatives meeting recorded a discussion around the recent transport, staffing and management issues in the home and the acting manager clarified the situation. This meant that the concerns were acknowledged, reported on and a plan was in place to resolve them.

Requires improvement

Is the service well-led?

Our findings

There was inconsistent monitoring of the quality of the service. The deputy manager acknowledged that limited audits had been undertaken in the past five months. They told us there has been no management support to guide them in this area or instruction from line management. The manager had identified the lack of audits through their monthly reviews. However, this was yet to be addressed. Regular checks were undertaken by the provider. They identified some of issues found at our inspection and there was an action place currently being worked through.

It was clear that the deputy manager had audited care plans to ensure they continued to meet the needs of people who used the service. However, this had not been a formal audit and resulted in post-it notes being inserted into care plans in areas that required updating. We saw that medicine audits had taken place monthly until November 2014. The deputy manager confirmed that there had been no further audits undertaken. Actions from this audit included to obtain a new controlled drug register. We saw that this action had been taken. The most recent quarterly safety audit had been carried out in November 2014 and infection control audit had been undertaken in December 2014. There were no resulting actions from these audits.

However, we saw areas of the house that required attention, such as the general maintenance and tidiness of the service that had not been identified or addressed through audits. In addition, issues in relation to food hygiene and kitchen record keeping which had been identified by the environmental health inspection undertaken in May 2013 remained an issue. For example, the way food was stored in the fridge and gaps on cleaning schedules.

Relatives told us that the service used a survey to gain their feedback. One said, “We used to have a regular survey to fill in from the organisation but haven't had one for a while.” We saw that there was an easy read format survey available to people who used the service which included a checklist response. However, it was clear that staff had completed the questionnaires on behalf of people. We could not be confident that these were people's own responses and here was no summary of responses or resulting action plan available for 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.

Relatives told us that they were concerned about the management arrangements in the home and they felt there was a lack of leadership. One relative told us, “The leadership is weak and provides no direction. The staff change has been significant and there have been loads and loads of change I feel that when the [registered] manager is in there they are a Godsend but when they are not there, it is not good.”

Relatives also told us that communication in the home was poor. One relative said, “I feel that there is something not quite right there. Whether it is staff training, staff recruitment or what I don’t know.” Relatives told us they had no faith in the management of the home outside of the registered manager who was now not there full time.

The registered manager was working in a regional manager role. The home had until recently been supported by a manager from another service. There were two deputy managers at the service. However, they needed more support and guidance than they were currently receiving as were running the service with little oversight or instruction by management. As a result, quality assurance systems had not been used and gaps in knowledge were not identified or addressed.

Staff told us they were aware of instability within the management team but told us that it hadn't impacted directly on them. This was because the deputy manager had provided them with good support and guidance. One staff member told us that the instability in the management team meant that there were lots of different senior people involved in the service with different ways of doing things. It was said they were, "Not singing from the same hymn sheet." This made it difficult for staff to work consistently.

There had been a recent staff meeting. Meeting notes included good detail of conversations held. For example, "The standard of personal care is to be that of your home – to include cleaning teeth twice daily, clean shaving for the men, brushing hair etc. Each member of staff should be taking pride in personal care." Another example was a conversation around paperwork: “There must be plenty of

Requires improvement

Is the service well-led?

evidence in all special notes, body charts and incident reports and all other paperwork. When filling out body charts you must make sure that marks bruises etc. added to the charts must be accurate." This meant that the deputy managers had given guidance to the team in relation to recent shortfalls identified in the home to help improve the standard of the service provided.

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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered person did not ensure people had their individually assessed needs met.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person did not ensure that systems in place to monitor and manage the quality of the service were effective.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered person did not ensure that staff were able to respond appropriately to an allegation of abuse.**

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 ensure that people supported in accordance with the Mental Capacity Act 2005.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

This section is primarily information for the provider

Action we have told the provider to take

There was not an effective complaints procedure in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person did not ensure that there were sufficient staffing numbers to enable people's needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person did not ensure that people were cared for by suitably trained and supported staff.