

Maranatha Housing and Support Ltd






Ecton Brook

Inspection report

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Date of inspection visit: 9 November 2015
Date of publication: 27/01/2016

Ratings

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

Overall summary

This announced inspection took place on 9 November 2015.

At the time of our inspection the service supported 2 adults with learning disabilities.

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.

There was a registered manager in post; however, they had not ensured that there was an adequate infra-structure to ensure there were sufficient systems and procedures to adhere to the regulations.

The provider had not ensured there were effective processes in place to monitor, assess and evaluate the service. This had led to failings in areas such as safeguarding, recruitment and staff training. There were no systems in place to ensure that policies and procedures to guide staff were reviewed and updated.

People were not always protected from the risk of poor practice or potential abuse, staff had not received

Summary of findings

training in safeguarding in the last two years and there were no up to date guidelines or policy to provide instruction for staff to follow to contact relevant external agencies.

Recruitment systems were not effective, the provider did not have a clear record of staff employment records and none of the staff had undergone recent disclosure and barring checks that related to their employment at the service.

Although staff received informal training from staff that had in-depth knowledge of the people that used the service, staff had not received formal training in areas such as fire awareness, first aid, manual handling, food safety, infection control, and health and safety. People had health conditions which required specific knowledge and skills, but the staff had not received training in how to manage these conditions. Staff administered medicines in accordance with people's prescriptions, but staff had not received training in medicines management.

People's risk assessments had not been regularly reviewed and not all risk assessments in place were relevant as people's needs had changed. Care plans did not always reflect the care that people received. People

The provider had not ensured that decisions about people's care was provided following assessment of their mental capacity, best interest meetings or by making an application to the court of protection. Staff did not understand their role in acting in accordance with the Mental Capacity Act 2005 (MCA 2005).

The manager and staff knew the people well and had a good knowledge of people's individual personal care needs that helped them to manage people's complex behaviours. People had been with the service for many years, and relatives were happy with the environment and with the staff providing their care.

People's routines were maintained which had a positive effect on their well-being. They had their own bedrooms and living spaces which reflected their own personalities. People were encouraged to take responsibilities and they were supported to maintain their relationships with their families. People received regular meals and were encouraged to maintain a healthy diet and staff involved them in choosing their menus and shopping.

There were enough staff allocated to provide care on all shifts, and staff were flexible in providing time to take people out. People received care from staff that had undergone a period of induction and staff received regular supervision with the manager and staff told us they felt supported.

Staff enabled people to attend their healthcare appointments by helping people to prepare for their appointments.

No complaints had been made by people who used the service or their relatives.

We identified that the provider was in breach of five of the Regulations of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3) and you can see at the end of this report the action we have asked them to take.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key

Summary of findings

question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more

than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 not always safeguarded from harm as the provider did not have systems in place to prevent, recognise and report any suspected signs of abuse.

People could not be assured that staff had been appropriately recruited and had the skills and experience to provide safe care.

People's care plans to mitigate assessed risks were not always updated.

People received their care and support from sufficient numbers of staff.

People's medicines were appropriately managed and safely stored.

Inadequate



Is the service effective?

The service was not effective.

The manager and staff did not understand their responsibilities as defined by the Mental Capacity Act 2005 (MCA 2005).

People received care from staff that had not received the training they needed to meet people's needs.

People received care from staff that had the supervision and support to carry out their roles.

People were supported to have sufficient to eat and drink to maintain a balanced diet.

People's healthcare needs were met.

Inadequate



Is the service caring?

The service was caring.

People's care and support took into account their individuality and their diverse needs.

People's privacy and dignity were respected.

People were supported to make choices about their care and staff respected people's preferences.

Good



Is the service responsive?

The service was not always responsive.

People's needs were not always met in line with their individual care plans and assessed needs.

Requires improvement



Summary of findings

Relatives could make complaints and be confident that their complaints would be dealt with. People relied on staff to advocate for their quality of care.

Is the service well-led?

The service was not well-led.

People were not assured that the manager had put in place an infrastructure that would protect them from risks associated with all aspects of the service, including recruitment, safeguarding and staff training.

People were not protected by quality monitoring systems designed to identify areas for improvement.

Staff records were disorganised

Policies and procedures were out of date and did not inform staff of the procedures they should follow to keep people safe.

There was a registered manager in post.

Inadequate



Ecton Brook

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 9 November 2015. The provider was given 48 hours' notice because the location provides a supported living service; we needed to be sure that someone would be in.

We also reviewed other information that we held about the service such as notifications, which are events which

happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies. This included the local authority who commissioned services from the provider and the local authority safeguarding team.

During our inspection we spoke with two people who used the service, one of their relatives, one member of staff and the registered manager. We also looked at records and charts relating to two people and two staff recruitment records.

We also looked at other information related to the running of and the quality of the service. This included quality assurance audits, maintenance schedules, training information for care staff, staff duty rotas, meeting minutes and arrangements for managing complaints.

Is the service safe?

Our findings

People were not always protected from the risk of poor practice or potential abuse. The registered manager and the staff team did not understand their responsibilities to safeguard people; they were not aware of the different types of abuse, did not know the signs to look out for and were unaware of how they would report this to the relevant authorities.

Staff had not received training in safeguarding in the last two years and there were no up to date guidelines or policy to provide instruction for staff to follow to contact relevant external agencies such as Care Quality Commission (CQC). The registered manager told us that one person who used the service had faced potential financial abuse from members of the public. This had not been recognised as a safeguarding concern or as potential abuse and they had not reported this to the safeguarding authority or to CQC. However the registered manager had felt that the person was vulnerable when out in the community and had directed that they must be accompanied by staff at all times. This level of control had not been assessed or agreed as necessary by relevant professionals and the person's rights had not been taken into account in this decision.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

People could not be assured that they were protected from the risks associated with the recruitment of new staff. Two members of staff were relatives of the registered manager, of whom one member of staff did not have any evidence that the required processes had been completed, there was no application form, interview record, proof of identity, or references. None of the staff had undergone recent disclosure and barring checks that related to their employment at the service. There was a risk that people were being cared for by staff that were not of good character or appeared on the disclosure and barring list.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

The registered manager had failed to take appropriate steps to ensure the health and safety of the people using the service or to protect them from avoidable harm.

Risk assessments had been completed in relation to some aspects of people's care and support needs, for example risks associated with travelling in a car and the risk of scalding from hot drinks due to poor eyesight. However we identified a number of issues with the risk assessment and management process and how this was used in practice. Risk assessments had not considered all aspects of risk associated with people's care and support needs and had not been reviewed or amended to reflect changes in people's behaviours or support needs. For example a person using the service was restricted from leaving the home without staff, yet there were two risk assessments and management plans that gave conflicting instructions to staff.

People were being restricted from leaving the service as the doors to the property were kept locked at all times, these locks required a key which was managed by staff, and therefore people were dependent on staff to allow them to leave. This restriction had not been risk assessed or considered in relation to people's rights and freedoms. In addition we were concerned about the overall approach to fire precautions in the property and noted that there had not been any fire drills and that there was no system in place to check that fire alarms or fire safety equipment was in working order. We informed the local fire protection officer of our findings. The manager told us they were arranging for new locks to be fitted to allow for exit without a key.

People were not always assured that staff understood what to do in an emergency. Staff demonstrated that they would call for medical assistance in an emergency, but none of the staff had received first aid training. Where people had had accidents, staff recorded these on incident forms and recorded their actions.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Staff administered medicines in accordance with people's prescriptions. Where people required additional medicines for example when they were in pain, systems were in place to provide them with prescribed medicines as they required. Staff provided a record of when they administered medicines, however, these were occasionally

Is the service safe?

not recorded. Staff understood the effect that alcohol had on the effectiveness of medicines, and helped people make decisions about their alcohol intake to maintain their health and well-being.

There were enough staff allocated to provide care on all shifts. Where people wanted to go out, extra staff were deployed to facilitate this. However, the knowledge and skills of the manager and staff had not been maintained or updated.

Is the service effective?

Our findings

People could not be assured that staff understood their role in acting in accordance with the Mental Capacity Act 2005 (MCA 2005) or that their rights to have choice and control over their day to day life, care and support were always respected. One risk assessment and related care plan directed staff to accompany one person at all times when they were in the community. However the provider was unable to demonstrate that the appropriate steps had been taken to agree this intervention through assessment of their mental capacity, best interest meetings or by making an application to the court of protection.

Staff had not received training in assessing people's mental capacity and did not understand or respect the need for a person to be considered as having capacity and therefore able to make decisions themselves. All people using the service were also restricted from leaving the service when they wanted to do as the doors were always locked with a key controlled by staff. . We contacted the commissioner for the care of people using the service and raised our concerns directly with them.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

People could not be assured that staff had the skills and training to provide care that met their needs. People had behavioural management needs that impacted on each other, staff and members of the public, which required staff skill to prevent and manage potential conflict. However staff had not received training in managing complex behaviours or conflict management and relied on each other to learn the skills and approaches to the care needed by each person. People using the service also had health conditions which required specific knowledge and skills in order to ensure safe care, i.e. epileptic conditions. However the staff had not received training in how to manage these conditions and again learnt from each other.

One member of staff described how they learnt the skills they needed 'on the job' and from guidance given by the registered manager. However there were no plans or systems in place to ensure that staff received formal training in areas that would provide them with the skills and knowledge they needed and to ensure that their practice reflected current good practice. They had not received formal training in core areas required to care for people safely including manual handling, infection control, first aid, medicines management and health and safety.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

People received care from staff that had undergone a period of induction; staff told us and in-house documentation showed that staff had been orientated to the building, read policies and got to know the people using the service. Staff received regular supervision with the manager and staff told us they felt supported.

People received regular meals and were encouraged to maintain a healthy diet. People told us that they had their favourite foods and staff involved them in choosing their menus and shopping. Staff prepared all the meals and there was guidance for staff on how to prepare food safely, for example using the correct chopping board for raw food. However, staff had not received training in food hygiene and there was no system in place to ensure that the fridge and freezer were maintained at the right temperature to store foods.

Staff enabled people to attend their healthcare appointments by helping people to prepare for their appointments such as the chiropodist, and health clinics. Staff accompanied people to healthcare appointments and respected their wishes to see health professionals alone.

Is the service caring?

Our findings

The manager and staff knew the people well and had a good knowledge of people's individual personal care needs that helped them to manage people's complex behaviours. One relative told us "staff fully understand [name] needs."

One person told us they liked the staff, they described them as "very nice" and said they enjoyed being with them; they spoke fondly of the activities they enjoyed with particular staff such as going out for walks. We observed the interaction between another person and a member of staff and saw that they appeared to know each other and enjoy each other's company.

People were appropriately dressed and well kept. Relatives told us how their behaviours had improved over the years and how happy they were with the service. Staff appeared respectful and maintained people's dignity by reminding them of appropriate behaviours.

People's routines were maintained which had a positive effect on their well-being. Staff were flexible about their shifts so that people could be supported to go out for activities such as shopping. Staff ensured that people had the means to carry out their chosen activities for example by ensuring that batteries were charged for their electric organ.

People had been with the service for many years and the provider had facilitated them to move house in the last year. One person told us they preferred the new home as they felt safe, they described how they preferred to go out on day trips as they liked to sleep in their own bed as it was safe.

Is the service responsive?

Our findings

People could not be assured that the care plans that provided instruction for staff on how to provide care were detailed and relevant. The care plans had been updated six months ago and provided some guidance for staff, however, not all care plans reflected the care that was being provided. For example care plans gave guidance on one person going out on their own when this was no longer the case.

People had been assessed for their needs such as personal care. Care plans were not regularly updated; they contained some information for staff to follow, however, they lacked clarity as some of the language used was confusing as the spellings of some of the text gave different meanings to the instructions. The care plans did not provide enough detail to inform staff on how care should be given in line with their assessments.

Staff were providing care to manage people's complex behaviours. The behaviours were not recorded and triggers that led to the challenging behaviours had not been documented. Although the manager and staff told us they knew some of the triggers and how to respond there was no clear plan of care that instructed staff on how to identify or manage these.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

People had their own bedrooms and living spaces which reflected their own personalities. One person told us they liked to play the electric organ which was in their living

room. Staff had recorded they played this for long periods and how much pleasure it gave them. Another person liked to rip up paper and we saw that staff had provided them with supplies of catalogues for them to do this.

People were encouraged to take responsibilities, for example one person was helped to care for their pets; they told us how important this was as they used to look after rabbits when they were younger. Staff supported them to purchase pet food and supplies and clean them regularly. Daily records showed that staff supported people to go for walks in the park, visit food outlets and shops. People were also involved in maintaining their home by helping with household chores and making packed lunches.

People attended a day centre most days of the week and staff liaised with the day centre if people's needs had changed.

People were helped to maintain their relationships with their families. Families were made to feel welcome when they visited and staff facilitated people to visit their family and provided support with managing their behaviours.

Relatives provided positive feedback about the service. Relatives could make complaints and be confident that their complaints would be dealt with. People relied on staff to advocate for their quality of care and complain on their behalf. Staff could recognise when people were unhappy and told us they would explore what had made them unhappy by spending time with them and talking over their experiences. Although no complaints had been made by people who used the service or their relatives, the manager had a system of responding to any complaints which was outlined in their policy.

Is the service well-led?

Our findings

The provider / registered manager had failed to embed systems and processes to effectively oversee the way in which care and support was being provided and to ensure that this was in line with expectations and regulatory requirements.

The procedural and operational infrastructure had not been formalised and relied upon word of mouth rather than provider guidance and direction. Policies were either not in place or were out of date and were not reflective of expected practice. For example the safeguarding policy had not been reviewed and failed to provide staff with the guidance they needed. There was no policy in place to ensure people's rights and freedoms were respected in relation to their capacity to consent to all aspects of their care and treatment. Staff were restricting peoples' freedoms and controlling their independent access to the community without following any process to ensure that these restrictions were necessary or legally bound.

The provider had not embedded safe recruitment practice. There was no recruitment policy or effective process in place to monitor the recruitment practice to ensure that staff had undergone the relevant checks. There was no system for assessing the risk of staff using checks from previous employment and the provider had not developed a policy or implemented good practice in relation to the renewal of Disclosure and Barring (DBS) checks for staff. This practice had left people at risk of receiving care from staff that had not undergone rigorous employment checks. At the time of our inspection there were no staff with an up to date DBS in place.

The provider had failed to embed an effective approach to staff training and development and had not ensured that staff had the skills and competencies required to care for all aspects of peoples care and support needs. There were no formal training program in place and staff relied upon learning from each other as the only means of skill

development. The last formal training to be undertaken by any member of staff was in relation to safeguarding practice and this had been carried out in February 2013. None of the staff had training in managing people's challenging behaviours or in conflict management for the last nine years. People were at risk of receiving care from people who did not have the training required to meet their needs.

The providers approach to record keeping lacked structure and organisation; records were chaotic and there were no audit systems in place to monitor or assess the adequacy of record keeping. Peoples risk assessments and care plans were inaccurate and did not reflect current support needs. The records for staff were disorganized; the record for each staff member was not kept individually. There had not been any quality monitoring such as an audit of the staff files to demonstrate that the provider had evaluated the information held about each staff member.

Following our last inspection the provider had implemented effective quality monitoring systems in relation to the cleanliness of people's home. However, there was no quality monitoring process in place to monitor, assess and evaluate any other aspect of the service or of the care and support provided.

The provider had failed to ensure that people were cared for within a safe environment, They had failed to monitor fire safety practice, people using the service and staff had not carried out any fire drills and there were no checks in place to ensure the fire safety measures in place were effective or in working order.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

The management promoted an open and honest culture and staff told us that they were able to approach management about any issues and they were listened to.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity

Personal care

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

The provider did not act in accordance with the Mental Capacity Act 2005 (MCA 2005). Regulation 11 (3)

The enforcement action we took:

We applied a condition to the registration preventing the provider from providing any new care packages.

Regulated activity

Personal care

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The provider had not assessed all the risks to the health and safety of the service users, or took any action to mitigate these risks. Regulation 12 (2a and b)

And

The provider did not ensure that staff had the qualifications, competence, skills and experience to provide care safely. Regulation 12 (c)

The enforcement action we took:

We applied a condition to the registration preventing the provider from providing any new care packages.

Regulated activity

Personal care

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Systems and processes are not established or operated effectively to prevent abuse of service users. Regulation 13 (1 and 2)

The enforcement action we took:

We applied a condition to the registration preventing the provider from providing any new care packages.

Regulated activity

Regulation

This section is primarily information for the provider

Enforcement actions

Personal care

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider did not have systems or processes in place to effectively assess, monitor and improve the quality and safety of the service provided. Regulation 17 (2a)

And

The provider did not have systems or processes in place to effectively assess, monitor and mitigate risks relating to the health, safety and welfare of service users. Regulation 17 (2b)

The enforcement action we took:

We applied a condition to the registration preventing the provider from providing any new care packages.

Regulated activity

Regulation

Personal care

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

Recruitment procedures were not established or operated effectively to ensure that staff employed were of good character and had the skills and experience necessary for the work to be performed by them. Regulation 19 (1a and 3a)

The enforcement action we took:

We applied a condition to the registration preventing the provider from providing any new care packages.