Creative Support Limited

Creative Support - Lodge Lane

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

This inspection took place on 21 and 23 January 2015 and was unannounced.

85 Lodge Lane provides accommodation and personal care for people who have a learning disability. This home is registered to provide a service for five people; on the days of our inspection three people were living there.

There was no registered manager in place. A manager had been appointed and had submitted an application to be registered with The Commission. 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.

We carried out a responsive inspection on 24 June 2014. We found that there were insufficient staff on duty and people's care needs had not been met. People did have access to routine health screening. Suitable arrangements were not in place to ensure people's

Summary of findings

dietary needs were met. Appropriate systems were not in place to safeguard people from potential abuse and there were no quality assurance audits in place to ensure people received an effective service. When we returned on 21 January 2015, we found that the provider had not made improvements and continued to be in breach of the regulations.

We found that the management of medicines were not effective and people did not always receive their prescribed treatment. At our previous inspection in June 2014, we found that the keys to the medicine cabinets were not maintained securely and were accessible to everyone in the home. When we returned on 21 January 2015, we found that the keys were kept in the kitchen and were accessible to everyone. This placed people at risk of accessing medicines that had not been prescribed for them.

During our inspection on 21 January 2015, we found that medical intervention was not provided in a timely manner to ensure people's health. Prompt action had not been taken to ensure people had access to special equipment to promote their health and comfort.

Staff were aware of people's needs and had access to care plans and risk assessments that told them how to care for people. Staff spoke to people in kind manner and responded to them when they indicated they needed support.

Staff did not have access to regular supervision and were not supported to undertake their role to ensure people received a safe and effective service. Staff had access to routine training but lessons learnt were not always put into practice.

We found that not all the staff had a good understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Discussions with staff confirmed that they were unaware of unlawful practices that could have an impact on people's freedom of liberty.

People were supported to pursue their interests outside of the home, such as swimming, shopping and restaurants. However, there was a lack of stimulation provided within the home. People who used the service lacked capacity to make a complaint. However, the provider's complaint procedure was not made accessible to visitors for them to share any concerns about the service provided.

There was no clear leadership and the acting manager confirmed that they did not have any management experience or a background in the caring for people who have a learning disability. We found that the provider had not taken sufficient action to address the concerns we identified at our inspection in June 2014.

Following the inspection we met with the provider to discuss the concerns we have found and the continued breaches of regulations. The provider acknowledged the shortfalls we identified and assured us that since our inspection action had been taken to address this. They told us that a new management team had been put in place. The provider sent out an action plan that showed what further action they had taken to improve services for people.

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.

There were not enough staff available to ensure people's care and support needs were met.

The management of medicines was unsafe and people did not always receive their prescribed treatment.

Requires improvement

Is the service effective?
The service was not effective.

People did not have access to medical intervention in a timely manner.

People did not have access to special equipment identified to meet their needs and this placed their health at risk.

The provider was unable to demonstrate when and how often people had access to food and drinks.

Staff's lack of understanding of the Mental Capacity Act and the Deprivation of Liberty Safeguards placed people at risk of not receiving the appropriate support.

Requires improvement

Is the service caring?
The service was caring.

Staff were aware of people's care needs and they spoke to people in a kind and caring manner.

People's right to privacy and dignity was not always promoted.

Good

Is the service responsive?
The service was not responsive.

There was a lack of staff interaction and in house activities for people who used the service.

Arrangements were not in place to enable people's representatives to share their concerns with the provider.

Requires improvement

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

The provider had not addressed the concerns identified at our previous inspection in June 2014.

The provider did not ensure that the home was managed by a manager who had the skills and experience to drive improvements.

Requires improvement

Summary of findings

There was no clear leadership and this had an impact on the care, support and treatment people received.

Creative Support - Lodge Lane

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

This inspection took place on 21 and 23 January 2015 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we had asked the provider to complete a Provider Information Return (PIR) which they did. This is a form that asked the provider to give some key information about the home, what they do well and improvements they plan to make.

We spoke with the local authority to share information they held about the home. The local authority had concerns about the service provided to people and had suspended placements at the home. We also looked at the information we held to see if we had received any concerns or compliments about the home. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We used this information to help us plan our inspection of the home.

At the time of our inspection three people were living in the home. The people who used the service did not have verbal communication and were unable to tell us about their experiences of using the service. We spent time with people and looked at how staff approached, supported and communicated with people. On the days of our inspection we spoke with four care staff, two acting managers and the service manager. We looked at three care records, three risk assessments, medication administration records, menus, incident reports and quality audits.

Requires improvement

Is the service safe?

Our findings

At our previous inspection in June 2014, we found that there were not enough staff to meet people's needs. The provider told us that they would increase the staffing levels. When we returned on 21 and 23 January 2015, we found that the staffing levels had not been increased and there were not enough staff provided to keep people safe. The acting manager and service manager told us that three care staff should be provided on each shift. On the days of our inspection there were two care staff. The acting manager said one person who used the service was in hospital and staff were allocated to support this person whilst in hospital. The provider had not reviewed the staffing levels to ensure that the remaining three people would be adequately supported. The service manager told us that they had asked the local authority for additional funding to increase the staffing levels but this had been refused. We saw that staff were nearby to assist people when required. However, staff told us that when they assisted one person with their personal care needs the remaining people were left unattended and this placed them at risk.

Staff told us that during the day a member of the management team were available to provide additional support to ensure people's care needs were met and we saw this. However, during the evening the management team were not available to provide support when needed. This placed people at risk of inadequate support and care. Staff told us that whilst a person was left unattended they entered the office and destroyed records. They said that there had also been a time when the same person was left unattended and they were later found in the kitchen and this placed them at risk of harm. The manager confirmed that these incidents had occurred. Another care staff said, "We learn to cope with only having two staff but when we assist [Person], the rest are left unattended."

This was a continued 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) Regulation 2014.

We found that the provider's recruitment procedure was robust to ensure that people who worked at the home were suitable to care for people. For example, two care staff told us that references were requested and safety checks were carried out before they commenced employment.

At our previous inspection in June 2014, we found that the keys to the medicines cabinet were not securely maintained. The provider sent us an action plan that told us a key cabinet had been purchased to store the keys for the medicine cabinet. However, at our inspection on 21 January 2015, we saw that the keys were kept in the kitchen and were accessible to everyone in the home. The provider was unable to demonstrate that medicines were safely maintained. We saw three prescribed medicines that were not stored securely. This placed people at risk of obtaining medicines that had not been prescribed for them.

People had not received their medicines when needed. We looked at three medicine administration records (MAR). A MAR is a record of people's prescribed medicines that staff sign to show when medicines had been administered. The MAR indicated that medicines were not always given to people. The provider's records showed that there had been three incidents where three people had not received their medicines. The manager told us that staff had forgotten to administer these medicines. The failure to ensure that people received their prescribed medicines placed their health at risk.

We found that 'when required' medicines had been prescribed for some people. These medicines were prescribed to be given only when needed. Staff did have access to robust instructions about how to manage these medicines safely. One MAR showed that a 'when required' medicine had been given to the person every day for several weeks and the GP had not been informed of this. A care staff said, "I give them the medicines because everyone else does." Another care staff told us, "This person's medicines needs to be reviewed." The provider had not taken any action to explore the reason why this medicine had been administered every day. The acting manager said that a GP appointment had been made to review the person's medicines. The acting manager was unable to explain why there had been a delay in contacting the GP.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People were unable to tell us if they felt safe living in the home. We spoke with two care staff who were aware of the importance of keeping people safe. A care staff told us

Requires improvement

Is the service safe?

about the importance of keeping the environment safe and the support people required to ensure their safety whilst in the community. All four care staff we spoke with confirmed that they had received safeguarding training and were aware of their responsibility of sharing any concerns of abuse with the provider and other agencies. A record of safeguarding referrals was maintained. However, there was no evidence of what action the provider had taken to reduce the risk of a reoccurrence.

Risk assessments were in place that told staff how to keep people safe. For example, one person had a health condition and we saw a risk assessment that told staff how to ensure their safety. The staff we spoke with were aware of the person's health condition and the support they required to keep them safe. We saw another risk assessment about how to safely support a person whilst in the community and the staff we spoke with were aware of how to support this person safely. The acting manager told us that accidents and incidents were recorded and we saw records of these. The provider's action plan showed that 'monthly managers' audits were carried out to review accidents. However, there was no evidence of this and the acting manager was unaware if accidents were routinely monitored to identify any trends or action taken to avoid a reoccurrence.

Requires improvement

Is the service effective?

Our findings

At our previous inspection in June 2014, the provider was unable to demonstrate that people had access to routine health screening. The provider's action plan showed that health action plans had been put in place to support people to attend medical appointments. At this inspection we found that one person was scheduled to attend a medical appointment in September 2014. Discussions with the service manager and the care records we looked at showed that this appointment had been cancelled by staff. The provider had not taken any action to rearrange this appointment. On the day of the inspection the acting manager told us that they had arranged a follow up appointment.

We saw that the same person's mouth was red and sore. Discussions with a care staff and records we looked at showed that these symptoms had been present for 16 days. During this time the person had started to refuse food and drink. Medical intervention had not been obtained for this person until the day our inspection. Records relating to this person showed they were underweight. A care staff said, "The person's weight loss has never been explored." The provider had not taken any action to ensure that this person was supported to manage their weight. The acting manager told us that a referral to a dietician had been made on the week of our inspection but was unable to explain why this had not been done earlier.

A healthcare professional shared information with us about the lack of support provided to people to manage their continence needs. One care plan showed that the person required continence aids. The acting manager was unsure if a continence assessment had been carried out to support the person with their continence needs. The acting manager said, "I wanted to introduce a continence programme to support this person but not all the staff would adhere to it." Therefore, the person was not provided with adequate support to manage their continence to promote their dignity.

One person required special equipment to assist them with their health condition. The provider had not taken the appropriate measures to ensure this equipment was suitable for use and the person did not have access to this equipment. In addition we found that the provider had not taken any action to ensure that a special chair designed to support the person's needs was suitably maintained and the person did not have access to this chair. The person was left in their wheelchair during the day. On the day of our inspection the manager made arrangements for the person to be reassessed for a new chair.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At our previous inspection in June 2014, we found that people were not provided with sufficient amounts of food. The care records we looked at showed that people had lost weight. We shared these concerns with the local authority under safeguarding procedures. At this inspection, there was more food in stock. The provider did not have any arrangements in place to show how many meals were provided during the day and the frequency these were offered. Staff told us that the last meal of the day was provided between 5pm and 6pm. One care staff said, "It depends on what staff are on duty to whether people are offered supper." This placed people of risk of not receiving food and drinks when required. Records were maintained of what people had eaten but accurate were not maintained of how much people had to drink and this meant the provider could not identify those people at risk of not having enough to drink.

One person lacked capacity to choose their meals and records showed they had been given the same cereal every morning. The acting manager said the person's diet should be varied. The provider's action plan showed people had been referred to a speech and language therapist (SaLT). However, records showed only one person had been referred. The provider was unable to demonstrate that people had access to relevant support to ensure they maintained a healthy diet.

Staff supervision was infrequent; the acting manager said that they did not have the skills and experience to supervise staff. Therefore, staff were not provided with the support they required to ensure people received a safe and effective service. Staff told us that they had access to routine training which included the management of medicines, epilepsy, moving and handling, safeguarding and induction. We found that not all staff had received Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) training and they lacked awareness of unlawful practices that had an impact on people's freedom of liberty. The MCA ensures that the

Requires improvement

Is the service effective?

human rights of people who may lack mental capacity to make a decision about their care and treatment are protected. DoLS are required when this includes depriving a person of their liberty to ensure they receive the appropriate care and treatment. We saw that a MCA assessment had been carried out for each person. People did not have mental capacity to be involved in decisions or to consent to their care, treatment and support. Best interest assessments were in place to ensure the care they received was in their best interest.

Good

Is the service caring?

Our findings

Staff had a good understanding about promoting people's right to privacy and dignity. They told us about the importance of closing doors and curtains when they assisted people with their personal care. We saw that people's personal care needs were carried out in a private area. However, minutes of a recent staff meeting advised staff to use a person's bedroom to carry out staff handovers. The acting manager told us that the person's bedroom had been used to carry out staff inductions. The acting manager acknowledged that this was inappropriate but did not feel confident to challenge this. Therefore, people could not be assured that their right to privacy would be respected at all times.

People did not have the capacity to be involved in decisions about their care planning. However, care records showed the involvement of other healthcare professionals and people's relatives. This ensured that staff had access to information about how to meet people's needs.

People did not have the capacity to express their needs. Staff had access to care plans and risk assessments that told them how to care for people. Care plans were detailed and told staff about the importance of recognising people's body language. For example, one care plan showed that when the person shakes their fist this would indicate anger or hitting their head would tell staff they were in pain. The staff we spoke with were aware of these signs and how to support the person. We saw that when people required support this was carried out in a kind and compassionate manner.

Requires improvement

Is the service responsive?

Our findings

People lacked capacity to be involved in their assessment and care planning. Care records showed that other healthcare professionals and the individual's relative had been involved in their care planning. Care plans provided staff with information about people's health condition and how to support them. Care plans also contained detail of how to support people to maintain contact with people important to them. Staff had a good understanding of people's needs and the support they required.

Staff told us that people were able to access leisure services within their local community and participated in a number of social activities. For example, swimming, bowling, day trips and going to the restaurant. A staff member told us that there was a lack of stimulation provided within the home. They said, "I was told that one person doesn't interact but they do. I show them want I am going to do and enable them to touch things, so they understand." During our inspection people were not provided with any stimulation, staff did not interact with them unless they indicated they needed support by pointing and making sounds. We saw one person looking out of their bedroom window listening to music from a neighbouring property. Staff told us that this person enjoyed listening to music. However, during our inspection we did not see staff support the person with this pastime.

People were not always able to tell the provider if they were unhappy and were reliant on staff or other healthcare professionals to recognise if the service provided had an impact on their wellbeing. For example, staff were aware of people's body language that showed if they were unhappy or in discomfort. The acting manager said that they had not received any complaints since our last inspection in June 2014. However, we found that there were no arrangements in place to enable people's family or representative to share their concerns. The manager confirmed that the complaint procedure was not accessible to people who visited the home. Therefore, people may not be aware of how and who to share their concerns with. Staff told us that they would share concerns or complaints on behalf of people with the acting manager. The acting manager assured us that the provider's complaint procedure would be displayed in the home and made accessible to all visitors. We found that a record of complaints prior to our inspection in June 2014 had been recorded and showed what action had been taken to resolve the concern.

Requires improvement

Is the service well-led?

Our findings

The provider did not have a registered manager in post. They had recently appointed a manager who had submitted an application to be registered with us. A staff member said, "The acting manager is very nice and friendly but they don't have any experience in management or caring for people who have a learning disability." The acting manager told us that they did not have any management experience and had never cared for people who had a learning disability. They were unaware of the concerns identified at our inspection in June 2014. They were also unaware of the provider's action plan. A staff member said, "There is a lack of consistency with managers and this has had an impact on the service. You don't know who to turn to for support." The provider had not taken suitable action to ensure that the home was managed properly and that people received an effective service.

The provider did not ensure that lessons learnt from staff training were used to improve services. For example, a care staff said, "We have recently commenced communication training but some staff say they tried it before and it didn't work." The acting manager was aware of some staff's lack of enthusiasm to drive improvement but confirmed they did not have the management skills to address this.

The provider had not taken sufficient action to address the concerns identified at our inspection on 24 June 2014. For example, the provider's action plan stated that staffing levels would be increased. However, we saw that there were inadequate staffing levels to ensure people's safety.

The provider did not have systems in place to ensure staff received supervision to support them in their role. The acting manager told us that they lacked the experience and skills to supervise the staff. A care staff said, "I don't have much experience and because of the lack of supervision I may have picked up some bad habits but I try to do everything properly." Another staff member told us, "Not having supervision makes me feel like I don't have a voice."

The provider did not take the appropriate action to ensure the management of medicines was robust. The acting manager told us that the concerns identified with the management of medicines had not been addressed with staff because they did not have the management skills to do this. Therefore, the necessary action had not been taken to ensure people received their prescribed medicines and this placed people's health at risk. The provider's action plan showed that an audit of medicines was in place. However, this audit did not identify the discrepancies we found during our inspection. Therefore, people remained at risk of not receiving their prescribed medicines. The provider's incident report identified that there had been three incidents where three people had not received their prescribed medicines in January 2015. The acting manager said that staff competency assessments for the management of medicines were carried out annually. However, a care staff who was responsible for the management of medicines said they had never had a competency assessment and the acting manager was unable to provide us with evidence of this.

Staff told us that they had access to routine staff meetings and we saw evidence of this. During these meetings staff were informed about people's changing needs and the service provisions. The staff we spoke with said they did not have access to staff surveys to enable them to share their experiences with the provider. Staff were aware of the shortfalls of the service provided. One care staff said there was a culture of 'We tried this before and it didn't work.'

We met with the provider after our inspection. They acknowledged the shortfalls we identified and told us that they had taken immediate action to address the concerns and to ensure people received a safe and effective service.

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 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
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 Appropriate measures were not in place to protect people against the risks associated with the unsafe use and management of medicines, by the means of appropriate arrangements for the handling, using, safekeeping, dispensing and the safe administration.

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. People did not have access to medical intervention in a timely manner and this placed their health at risk. Arrangements were not in place to ensure people had access to special equipment identified to meet their assessed needs.

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

This section is primarily information for the provider

Action we have told the provider to take

There were insufficient staffing levels to meet people's assessed needs and to keep them safe.

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not take appropriate action to address the concerns we identified at our previous inspection in June 2014. The provider's audits were ineffective and did not identify the shortfalls we found at our inspection on 21 January 2015.

This section is primarily information for the provider

Enforcement actions

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