Care Quality Commission

Inroads (Essex) Ltd

Wolves Lodge

Inspection report

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Date of inspection visit: 30 September 2015
Date of publication: 08/12/2015

Ratings

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

Overall summary

The inspection took place on 30 September 2015 and was unannounced.

The service is registered to provide care and support to three people with learning disabilities and autistic spectrum disorder. At the time of our inspection three people were using the service.

There was a registered manager in post but they were in the process of de-registering and a prospective registered manager was already in post to replace them. 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.

Staff were trained in safeguarding people from abuse and systems were in place to protect people from all forms of abuse including financial. Staff understood their responsibilities to report any safeguarding concerns they may have.

Summary of findings

Risks had been assessed and actions taken to reduce these risks. However risk assessments, although detailed, had not been appropriately reviewed, with some of them last being reviewed over 2 years ago which meant we could not be certain they reflected people's current needs

Staffing levels did not always reach the required number needed to keep people safe. Recruitment procedures, designed to ensure that staff were suitable for this type of work, were not always robust.

Medicines were administered safely and records related to medicines were accurately completed. Supporting information related to medicines was not always in place which could have placed people at risk.

Staff training was not up to date and some staff had not received important updates to enable them to carry out their roles safely and effectively.

Most staff had received training in the Mental Capacity Act (MCA) 2015 and Deprivation of Liberty Safeguards (DoLS). The MCA and DoLS ensure that, where people lack capacity to make decisions for themselves, decisions are made in their best interests according to a structured process. Where people's liberty needs to be restricted for their own safety, this must done in accordance with legal requirements. Although applications had been made to restrict people's liberty they did not contain information about restrictive physical intervention..

People were supported with their eating and drinking needs and staff helped people to maintain good health by supporting them with their day to day healthcare needs.

Staff were very caring and treated people respectfully making sure their dignity was maintained. Staff were positive about the job they did and enjoyed the relationships they had built with the people they were supporting and caring for.

People, and their relatives, were involved in planning and reviewing their care and were encouraged to provide feedback on the service. Care plans had not been appropriately reviewed and therefore it was not clear if they reflected current needs.

No formal complaints had been made but informal issues were dealt with appropriately although records were not always kept.

Staff understood their roles but were not always well supported by the management of the service..

Quality assurance systems were in place but action had not been taken promptly to address concerns. Record keeping was poor and there was a lack of management oversight of the day to day running of the service and the issues staff faced

At this inspection we found that there were breaches of four regulations of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have 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.

Recruitment systems were not robust and were not followed in all cases.

Systems were in place and staff were trained in safeguarding people from abuse.

Risks were assessed and action taken to minimise them but information was not always current.

Staff were trained to administer medicines and medicines were given to people as prescribed but information systems related to medicines were not clear.

Requires improvement

Is the service effective?
The service was not effective.

Staff did not all receive the training they needed to carry out their roles.

The service had not followed legal requirements relating to the deprivation of people's liberty and the use of restrictive physical intervention.

People were well supported with their dietary and healthcare needs.

Requires improvement

Is the service caring?
The service was caring.

Staff were patient, compassionate and kind and relationships between staff and the people they were supporting were good.

People and their relatives were involved in decisions about their care and their choices were respected.

People were treated with respect and their dignity was maintained.

Good

Is the service responsive?
The service was not always responsive.

People, and their relatives, were involved in assessing and planning their care but care plans had not been appropriately reviewed to ensure their current needs were reflected

People's choices and preferences were recorded in their care plans..

There was an accessible complaints procedure. One informal complaint had been responded to but no record of this had been kept.

Requires improvement

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

Requires improvement

Summary of findings

Staff understood their roles but were not always well supported by the management team. New staff did not receive a structured and supportive induction.

Record keeping was poor and there was a lack of management oversight of the day to day running of the service and the issues staff faced.

Wolves Lodge

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 30 September 2015 and was unannounced.

The inspection team consisted of one inspector.

Before we carried out our inspection we reviewed the information we held on the service. This included statutory notifications that had been sent to us in the last year. A notification is information about important events which the service is required to send us.

We observed care and support being provided for two people who used the service and met with three care staff, the newly appointed unit manager, the prospective registered manager, the current registered manager and one of the directors.

We reviewed three care plans, two medication records, three staff recruitment files and staffing rotas covering four weeks. We also reviewed quality monitoring records and records relating to the maintenance of the service and equipment.

Requires improvement

Is the service safe?

Our findings

According to the service's recruitment policy staff who were considered suitable for employment at the service should complete an application form, attend for interview, have their references checked and have their suitability to work with this client group checked with the Disclosure and Barring Service. We found that the service's own policy with regard to safe recruitment practices had not been followed in all cases and that this posed a potential risk to the people who used the service. We discussed this issue with the management of the service as a failure to ensure that staff were recruited safely had been identified twice in recent months. We found that lessons had not been learned and actions had not been effectively put in place to reduce the risk. They explained that they would now be taking additional steps to ensure that staff were recruited safely.

This was a breach of regulation 19 of the Health and Social Care Act 2008 Regulated Activities Regulations (2014).

We found that staff knew how to spot the signs of abuse and take appropriate action. Staff were able to tell us what they would do if they suspected or witnessed abuse and knew how to report issues both within the company and to external agencies directly. Financial procedures were in place that were designed to protect people from financial abuse. We checked balances of monies held and found they were correct and records had been accurately completed.

Staff had received online and face to face training in safeguarding people from abuse and this training was refreshed every two years. One person had not had any update to their training since 2011 which meant there was a risk that they may not be aware of current procedures.

We saw that risks associated with people's day to day activities such as, eating and drinking, travelling in a vehicle and taking medicines had been assessed. Risk assessments contained specific detail, such as the likelihood of one person removing their seatbelt whilst travelling in the car. Actions to minimise each risk had been identified and shared with staff and relatives of people who used the service.

Each person had a general risk assessment which covered risks such as taking their medication and accessing the local community and we saw that these had been reviewed recently for two people but the third had not been reviewed for over 18 months. We saw other risk assessments which were either undated or more than two years old. We also saw that there were multiple copies of some assessments. One person's file contained seven copies of the same assessment. Although this had the potential to confuse staff we found that this seemed to be a records issue and staff were clear about the risks at the service and how to minimise them. There were also risk assessments covering things like the reduced staffing levels at night and the use of knives in the kitchen. There was a business continuity plan which documented how the service would continue to be delivered in the case of an emergency.

People received care and support from staff who knew them well. Agency staff were occasionally used but we saw that the same staff were used as much as possible to help to ensure a consistent approach .In an emergency, or for added support, staff at the service could call on help from colleagues at another of the provider's services located next door.

The new service leader told us that each person required one to one staffing in the service and two people required two to one staffing in the community. We looked at rotas for the eight week period leading up to our inspection. We saw that on several occasions staff numbers had been less than those assessed by the provider as safe. There were 20 occasions where shifts had run with two staff rather than three throughout the whole shift or for part of it. This staffing level would have made it very difficult for those people who require two staff in the community, to go out. Staff told us that staffing had been a concern but there was a recognition that recent management changes and recruitment had begun to improve matters. One staff member said, "The two to ones [staffing] are now better –getting better. It's going forwards".

There were systems in place for the safe ordering, storage, stocktaking, administration and disposal of medicines. We saw that each person had their own lockable cabinet in their bedroom and medicines were administered by staff who had received the required training and had their competency checked before they were able to administer medicines as part of their role. These competency checks were not repeated which meant that there was a risk that poor practice would not be promptly identified.

Requires improvement

Is the service safe?

Although medication administration record (MAR) charts had been fully completed we saw that there was no additional information about the medicines people were taking and staff were not all clear about what people's medicines were for. We found that there were no protocols in place for homely remedies, such as hay fever tablets and prescribed medicines which people took only occasionally, such as an inhaler. We could not be assured that homely remedies were safe to take with people's other medicines. It was also not clear how staff would know how much medicine to give and for how long before they contacted a healthcare professional.

Stocktaking procedures were mostly accurate but we did also find some confusion over whether some medicines had been discontinued as they continued to appear on the MAR chart even though they had been returned. Records were sometimes confusing although, on investigation, people were receiving medicines they were currently prescribed.

Requires improvement

Is the service effective?

Our findings

We noted that people's consent was asked for before care and treatment was provided and the management and care staff had received training and demonstrated an understanding of the Mental Capacity Act (MCA) 2005. Where a person's liberty and freedom to leave the service needs to be restricted for their own safety, an application has to be made to the local authority to comply with the Deprivation of Liberty Safeguards (DoLS). We saw that DoLS applications had been made in January 2015 for all three people who used the service as they were under constant supervision and doors were kept locked. These applications were still awaiting consideration by the local authority. However when we spoke with a representative from the local authority they told us that the forms had not yet been correctly submitted.

We were concerned that the DoLS application for one person did not mention the use of restrictive physical intervention or restraint although we saw that this was regularly used for this person. This person had 33 incidents of restrictive physical intervention documented during 2015. The other two applications documented 'occasional deflection and escort restraint' but we saw that physical intervention and restraint was also used with these people. One incident described the person being physically restrained for two minutes on the floor in the recovery position. Although the risk assessment related to restrictive physical intervention had been shared with people's families and various holds demonstrated to them, it was not always documented how long a particular hold should be maintained.

Reasons for physical intervention were not always robust. For example one incident related to a person becoming upset because they asked for a cracker and this was refused. This then led to them becoming distressed and staff using restrictive physical intervention techniques. When we questioned this incident staff told us that they felt the record had been badly worded but we remained concerned as there were a number of similar documented incidents.

We were also concerned that there was no management oversight of incidents of restrictive physical intervention. The booklet where incidents were recorded had a section for managers to review the incident, comment, sign and take forward any learning points. We found that this had only been filled in twice on all the records we looked at. This meant that where questions might have been raised about the need for physical intervention or the management of particular incidents this had not taken place.

This was a breach of regulation 13 - 4 b of the Health and Social Care Act 2008 Regulated Activities Regulations (2014).

The people who used the service were not able to tell us about the care and support they received but we observed interactions between staff and the people who used the service throughout the day. We saw that staff met people's needs in a skilled and competent manner which demonstrated that they knew the people well. We observed one staff member supporting a person to bake some bread rolls and another helping someone with some sensory play.

Training records showed that staff received training to help them carry out their roles. However some training had not been provided for all staff and some training was overdue. For example one member of staff had not received moving and handling training for three years and another for over four years. Physical intervention training was documented as being provided annually and we saw that physical interventions were frequent at the service. Three of the nine staff had not had this training in the last two years. Fire training, safeguarding and food hygiene were similarly overdue for some people.

When staff first started working at the service they received an induction. New staff spent time shadowing permanent staff and then began to work as a full member of the team. We looked at the staff file for one of the newer members of staff. It contained no records of any meetings during the person's probationary period and no supervision sessions had been held. Although the person had undertaken training during this period, it was not clear how they had been supported and what oversight the management had of their work. They confirmed that they had not had any structured support but had taken advantage of the open door policy of the management if they wanted to discuss anything but this was not recorded. The service's own policy stated that new starters should meet with their supervisor during the first and second week and then monthly after that.

Requires improvement

Is the service effective?

Supervision sessions for permanent staff were also not held regularly. We saw that one member of staff had received only one supervision session in 2015 and others files showed a similar lack of support. An annual appraisal system was not in place.

This was a breach of regulation 18 – 2 a of the Health and Social care Act 2008 Regulated Activities Regulations (2014).

We observed staff supporting people to prepare their meals and ensure they had access to food and drink. People were encouraged to make their own choices about food and drink. The service was in the process of trialling different meals and recording if people liked them or not. If they were popular they were included in the new rolling menus which the service was preparing. The service encouraged healthy eating and supported people to choose and eat a healthy and varied diet. There was a commitment to providing homemade foods cooked from scratch and people were involved in preparing their meals. People's food preferences were recorded in their care plan and staff demonstrated a good knowledge of people's dietary needs. People were supported to maintain a healthy weight and referrals were made to dieticians if needed.

People were supported with their healthcare needs and staff worked in partnership with a variety of healthcare professionals to meet people's need promptly. Records confirmed that people attended dentist and optician appointments regularly with the support of the staff and advice was sought promptly from healthcare professionals, such as GPs, if someone became unwell.

Good

Is the service caring?

Our findings

We observed that people appeared happy with the way staff provided care and support. Staff demonstrated that they knew people very well and used distraction techniques when a person showed signs of distress. People were engaged in activities they had chosen and staff respected their wishes.

Staff chatted with people in a relaxed way and were patient, compassionate and caring. Staff demonstrated patience when asking people questions and waited until they were sure the person understood them and had given their answer before moving on. We observed that staff demonstrated that they had an equal relationship with the person they were supporting and listened to them and respected their decisions. We observed one member of staff planning and preparing to cook the dinner with one of the people who used the service. It was made clear that this was a shared responsibility and the person clearly enjoyed their time in the kitchen.

The service did not use an independent advocacy service but did consult families who acted as advocates for people occasionally. Staff also took this role on, such as one member of staff who was advocating for one person to be enrolled in a mainstream cookery course at the local college.

We saw that care plans had been drawn up in consultation with the person they concerned and had been shared appropriately with their relatives. Information was shared with people who used the service in a way they understood and information about people's likes and dislikes was captured in different ways. For example some information contained pictures and signs. We saw that one person's support plan contained feedback forms which used symbols. These forms recorded the person's response to questions such as, 'Did you enjoy your walk?' or 'Do you like your room?' The forms were not all dated but appeared to be done on a monthly basis. Staff told us that some people used Makaton signs as part of their communication but most staff had received no formal training in Makaton.

Staff respected people's privacy and we saw that people were enabled to spent time alone within the service if they wanted to. People's personal information and care plans were kept private. Care, especially personal care, was offered discretely in a way which maintained the person's dignity. Consideration had been given to how people would be supported when out in the community so that their dignity would be maintained.

Requires improvement

Is the service responsive?

Our findings

A placement assessment was carried out before people moved in to the service. We saw that this assessment was detailed and aimed to ensure that the service could meet people's particular needs. This assessment formed the basis of their care and support plan. We found that care plans were not subject to ongoing review and therefore did not reflect any changes in people's needs promptly. Care plans had last been reviewed in June 2014 and contained conflicting, duplicated and undated information. This meant we could not be assured that staff, especially new and agency staff, were always aware of people's current needs.

Care plans, although detailed in many areas, did not recorded if people preferred to receive care, particularly personal care, from care staff of the same gender. We also saw that although incidents of restrictive physical intervention were well documented, there was not always information available in care plans to inform staff how to minimise people's anxieties in order to reduce the need for physical intervention. Plans had been shared with relatives of people who used the service but were mostly not accessible to the people they concerned, although some had a section called All About Me which contained photographs and pictures. Staff told us that one person has started to send a weekly update to their relatives to keep them informed.

The management of the service had acknowledged that people who used the service should have more opportunities for social outings. Rotas had been reviewed and were planned to enable people to access the community to take part in social activities and local events more often. Staff told us that one person's one to one hours were used creatively so that they could go into the local town more regularly. Staff also supported people to go on an annual holiday.

It was clear that people were supported to follow their own hobbies and interests within the service. One person was watching a film and told us this was a favourite. We also saw a lot of creative artwork displayed around the service and in people's rooms. Sensory games and cookery were also clearly popular hobbies.

People who used the service met with their keyworker to discuss what they wanted to do and things they wanted to achieve. One member of staff explained to us that they were discussing a possible cooking class at a local college for one person who had a particular interest in cookery. Review meetings were held annually with parents to discuss people's care and to receive feedback. In addition surveys were sent out and invited parents to raise any concerns.

We saw that one person had raised a number of concerns in their response and the management of the service told us that they had met with the parent to discuss and resolve their concerns. We asked to see minutes of this meeting or their written response but neither had been produced. There had been no formal complaints made to the service in the last year, although this survey could be said to constitute a complaint. The service had a suitable complaints policy and each person had an accessible version of this in their rooms.

The service is a transition service which takes people from children and young people's services and works with them for a period of time before preparing them to move on to suitable adult services. We discussed how the service works with other professionals within the transition process. We found that the picture was mixed. Whilst there was an appreciation that the service worked very well for some people and that some staff were very impressive, there was also a feeling that sometimes communication was very poor. Meetings were often cancelled and information was not always provided promptly. One professional had found this frustrating as the transition process had slowed up. They said' "It's been so difficult to arrange the next steps". The management of the service had already begun to address this area and a meeting had recently been held with the people who used the service, parents and social workers.

Requires improvement

Is the service well-led?

Our findings

Although the service had begun to implement some changes which were designed to improve the quality of the service we found that the impact of recent ineffective management had been significant. Staff had not been safely recruited in all cases and had not been consistently trained, supported or given appraisals. In addition there had been a lack of oversight with regard to staff hours and staff performance. We were also concerned about the lack of oversight for the frequent restrictive physical intervention that occurred. We raised this with the prospective registered manager and asked how the service picked up trends and patterns related to restrictive physical intervention and they acknowledged that they did not do this.

A new monthly audit system had been put in place to monitor the quality and safety of the service. We looked at the last audit which had been carried out in August 2015 and saw that a detailed action plan had been drawn up to address the issues it raised. An external quality assurance audit had previously taken place in November 2014 and a number of concerns had been identified. We noted that many of these issues were still unresolved on the August audit although there was now a plan in place to take them forward.

We found that records were not organised well and provided a confusing picture for staff. Although the management of the service had begun to address this issue we found that records currently in use were not accurate. The management section of the restrictive practice records had not been completed, care plans had not been reviewed appropriately and care plan folders contained undated, duplicated and conflicting records. This could cause confusion for staff and it was not clear to us what people's most current needs were.

This was a breach of regulation 17 - 2 a, c of the Health and Social Care Act 2008 Regulated Activities Regulations (2014).

The service had undergone a lot of changes in management in recent months and a complete restructure had taken place which was designed to improve the management oversight of the service. There was a registered manager in place but they were in the process of de-registering with the commission and a new application was being made for a longstanding member of staff to take up the responsibilities of this role. Staff told us they were positive about the changes proposed and had already felt that things had improved.

New staff were positive about the supportive culture within the service and felt that, although structured support had not always been provided, they could approach the management team with any concerns they might have. One established member of staff said, "The new management changes are fantastic. There is lots more structure to our days and now we are being shown how to do things. Communication is much better". It was intended that the prospective registered manager would be much more available in the service on a regular basis to act as a role model, provide support for the staff and more effectively oversee the delivery of the service.

The annual surveys showed that some relatives had been concerned about the frequent changes in management at the service and lack of communication about this. We saw that they had been informed about the proposed restructure and the reasons for it. We found that in recent weeks there had been a commitment to improving communication between the service and the relatives of those that lived there.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Care was provided which was intended to control or restrain service users but which was not necessary to prevent, or not a proportionate response to a risk of harm posed to the service user or another individual. Regulation 13 4 b.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems had not been established to effectively assess, monitor and improve the quality and safety of the service or to maintain accurate, complete and contemporaneous records for service users. Regulation 17- 2 a and c.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had failed to provide staff with appropriate support, training, supervision and appraisal. Regulation 18- 2 a.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

This section is primarily information for the provider

Action we have told the provider to take

The provider did not have effective recruitment systems in place to ensure that persons employed were of good character and had the qualifications, competence, skills and experience necessary to carry out their work.

Regulation 19 - 1 a, b and 2 a.