Potensial Limited

16 Crompton Street

Inspection report

16 Crompton Street
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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 10 October 2016 and was announced.

16 Crompton Street is a residential service which provides accommodation and personal care for a maximum of seven people. At the time of the inspection three people were living at the service.

A registered manager was not in post. However the manager of the service was in the process of applying to become the registered manager. The manager was unavailable on the day of the inspection. 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.

The provider had implemented an approach to quality monitoring which was appropriate for the size of the service. However, these processes had failed to identify issues relating to the completion of essential safety checks and missing references.

We have made a recommendation about this.

The service had processes to monitor safety and employed external contractors to service and check; gas safety, electrical safety and fire equipment. We saw that checks had been completed in each area within the previous 12 months.

Risk to the people living at the service was appropriately assessed and recorded in care records. Each risk assessment focused on maximising the person's independence while safely managing any risks and had been recently reviewed. People told us they were involved in decisions about care and taking risks.

Medicines were safely stored and administered. However the service did not have an effective procedure in place to monitor stock levels.

Staff had the skills and knowledge to meet the needs of the people living at the service. Staff were required to complete a programme of training which included; first aid, administration of medicines, people handling and adult safeguarding. The training matrix provided indicated that all training required by the provider was up to date.

The people living at the service were actively involved in choices about food and drink and had free access to the kitchen. We were told that they were being supported to be more independent with shopping and food preparation.

People living at the service were supported to maintain good health by accessing a range of community

services. We were told that they had a GP, optician and dentist and had regular check-ups. We saw evidence of this in care records. We also saw evidence of health action plans which detailed a range of healthcare needs and other important information.

Throughout the inspection we observed staff interacting with the people living at the service in a manner which was compassionate and caring. We saw that staff spoke regularly with the people living at the service. They explained what they were doing and discussed their needs and activities. Staff knew the care needs of the people well.

We saw that people had choice and control over their lives and that staff responded to them expressing choice in a positive and supportive manner. With the exception of the administration of medicines, it was clear that the provision of care was not task-led and did not adhere to a fixed timetable.

Information was provided in a way that made it easier for people to understand. Staff took time to re-word things when people didn't initially understand. We saw that some important information, for example consent documents, were produced in plain English and made use of images to support people's understanding.

Privacy and dignity were protected and promoted by staff. Staff spoke with respect about the people living at the service and promoted their dignity in practical ways. Each person had a lock on their bedroom door for additional privacy and security. All confidential information was stored securely in an office within the service.

We saw from our observations that the people living at the service were involved in discussions about care on a day to day basis. We also saw evidence that people were actively involved in regular reviews of their care. Each person had a monthly 'keyworker' review which was signed by the person and the staff member.

The people living at the service were supported to follow their interests and an activities file was maintained which included photographs and comments from people living at the service. Activities were also discussed and planned at regular 'service user' meetings.

The service had been developed with input from the people living there and the staff team. Communication between staff and the manager was open and regular. We saw evidence that staff meetings had taken place regularly. Information relating to people living at the service and developments had been shared at the meetings.

Staff were clearly motivated to do their jobs and enjoyed working at the service. Staff understood their roles and demonstrated that they knew what was expected of them.

Records indicated that notifications of important events had been submitted to the Care Quality Commission appropriately. Safeguarding referrals to the local authority had been made in an appropriate and timely manner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us that they felt safe living at the service.

The service had processes to monitor safety and employed external contractors to service and check essential equipment.

Risk was appropriately assessed by experienced staff and reviewed on a regular basis.

Staff were safely recruited subject to the completion of appropriate checks and the receipt of satisfactory references.

Is the service effective?

Good

The service was effective.

Staff were suitably trained and supported to ensure that they could meet the needs of the people living at the service.

There was a good choice of food available. The people living at the service were encouraged to assist in the preparation of meals.

The service adhered to the principles of the Mental Capacity Act 2005. People gave their consent to the provision of care.

Is the service caring?

Good

The service was caring.

Staff interacted with the people living at the service in a manner which was kind, compassionate and caring.

The people living at the service were consistently involved in conversations about their own care and contributed to making decisions based on information provided by staff.

Staff adapted their communication style to meet the needs of the individuals and the circumstances.

Is the service responsive?

Good

The service was caring.

Staff interacted with the people living at the service in a manner which was kind, compassionate and caring.

The people living at the service were consistently involved in conversations about their own care and contributed to making decisions based on information provided by staff.

Staff adapted their communication style to meet the needs of the individuals and the circumstances.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service had been without a registered manager for an extended period.

Quality audit systems had not been effective in identifying issues highlighted during the inspection.

Staff were clearly motivated to do their jobs and enjoyed working at the service.

16 Crompton Street

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 10 October 2016 and was announced. 72 hours' notice was given because the service is a small care service and the people who live there are often out during the day. We needed to be sure that someone would be in.

The inspection was conducted by an adult social care inspector.

We checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all of this information to plan how the inspection should be conducted.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with two people living at the service, two staff and the area manager. We also spent time looking at records, including three care records, four staff files, staff training plans, policies and other records relating to the management of the service. We also observed the delivery of care at various points during the inspection.

Good

Is the service safe?

Our findings

Staff were recruited subject the completion of appropriate checks. This included a requirement for two references and a Disclosure and Barring Service (DBS) check. DBS checks are used to determine that people are suited to working with vulnerable adults. Some of the staff records that we checked contained an application form, references, DBS check and identification. However, references were missing from two staff records. An important risk assessment was missing from another staff record. We were told that some staff information was held at a different location. Copies of the references and the risk assessment were provided after the inspection.

The service had processes to monitor safety and employed external contractors to service and check; gas safety, electrical safety and fire equipment. We saw that checks had been completed in each area within the previous 12 months. The service had a general evacuation plan in place and tests on emergency equipment were conducted and recorded regularly. People also had a personal emergency evacuation plan (PEEP) in their care records. Staff had been involved in emergency planning training in July 2016. The service had a fire-resistant document folder to be used in the event of an emergency evacuation. However, the bag did not contain all of the important information that would be required to safely evacuate the building. For example, the PEEPS and plans of the building. The service had been audited by the Merseyside Fire and Rescue Service in September 2016 and rated as adequate.

We asked two of the people living at the service if they felt safe. One person said, "I feel safe living here." Another person said that they sometimes felt unsafe because of other people's behaviours. They added that staff supported them well when other people's behaviours caused them concern. Staff clearly understood different types of abuse and neglect and what signs to look out for. Staff also knew what action to take if they suspected that abuse was taking place. A member of staff said, "I'd know what to do if anything was wrong. I could speak to people outside [of the company] if I needed to whistle-blow."

Risk to the people living at the service was appropriately assessed and recorded in care records. We saw risk assessments relating to; absconding, aggression and maintaining health. Each risk assessment focused on maximising the person's independence while safely managing any risks and had been recently reviewed. People told us they were involved in decisions about care and taking risks. For example, one person told us about their plans to go out without support.

Accidents and incidents were recorded in appropriate detail and assessed by the manager. The manager was required to submit information electronically to the provider. The information was then analysed to identify patterns and triggers.

The service had sufficient staff to meet the needs of the people living there. There were a minimum of two members of staff per shift with extra provision depending on activities. A waking-night staff was provided between the hours of 10:00 pm and 8:00 am. The manager was available to provide or organise additional support as required. The area manager highlighted that the service was actively recruiting and moving staff from other services to reduce its reliance on the use of agency staff.

We checked the service's procedures for the storage, administration and recording of medicines. We saw that medicines were stored safely and securely and that staff maintained a record of administration. The supplying pharmacy did not always provide printed Medicine Administration Records (MAR) which meant that the staff had to hand-write some of the MAR sheets. The service was in the process of changing pharmacies. We were told that all MAR sheets would be printed and provided by the new pharmacy once the transition was completed. We saw that PRN (as required) medicines' protocols were in place for pain relief and anxiety. The records that we checked had been completed correctly and indicated that medicines had been administered as required. However, the service did not have an effective system in place for monitoring stocks. While new medicines were counted on receipt, the service did not record a starting balance of existing stock. This meant that the provider could not check stock to see if medicines had been administered as indicated on the MAR sheets. We asked the area manager and a member of staff about this and they agreed to include the opening balance of all medicines on the relevant records as a priority.

None of the people living at the service at the time of the inspection were prescribed controlled drugs. A Controlled Drug is a medicine that is controlled under the Misuse of Drugs regulations (and subsequent amendments). However, staff were aware of the additional requirements for the safe storage and administration of controlled drugs should they be required in the future. We were also told that none of the people currently living at the service used topical medicines (creams).

Good

Is the service effective?

Our findings

Staff had the skills and knowledge to meet the needs of the people living at the service. Staff were required to complete a programme of training which included; first aid, administration of medicines, people handling and adult safeguarding. The training matrix provided indicated that all training required by the provider was up to date. The induction process was aligned to the care certificate which requires staff to complete a programme of learning and be observed in practice by a senior colleague before being assessed as competent. A person living at the service told us, "Staff know what they're doing." Another person said, "Staff are well-trained." A member of staff who had recently returned to the service told us, "I got a new induction when I came back. I have other training [refreshed] every year."

Staff were given regular formal supervision and appraisal which was recorded on their file. They were also given regular informal supervision and support by the manager. A member of staff said, "[manager] always asks how you are. [Manager] is always there is you need anything." Another member of staff told us, "I get supervisions every two months and an annual appraisal. We also have team meetings. The manager is here every day if you want to speak to them."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

None of the people living at the service was subject to a DoLS. People's consent to various aspects of their care had been sought and recorded on their care files. In the majority of cases people had signed documents to confirm that they had given consent. For example, for staff to administer their medicines or hold money on their behalf.

The people living at the service were actively involved in choices about food and drink and had free access to the kitchen. We were told that they were being supported to be more independent with shopping and food preparation. One person living at the service told us, "I get to choose what I want to drink and eat. I peel the spuds." A member of staff said, "People choose and plan every week. We encourage healthy eating. We assist them to prepare their own meals."

People living at the service were supported to maintain good health by accessing a range of community services. We were told that they had a GP, optician and dentist and had regular check-ups. We saw evidence of this in care records. We also saw evidence of health action plans which detailed a range of healthcare needs and other important information.

Good

Is the service caring?

Our findings

Throughout the inspection we observed staff interacting with the people living at the service in a manner which was compassionate and caring. One person living at the service told us, "Staff always speak to me nicely. All of them are my favourites." Another person said, "Staff treat me well. I'd put in a complaint if they didn't." We saw that staff spoke regularly with the people living at the service. They explained what they were doing and discussed their needs and activities. Staff knew the care needs of the people well. For example, one member of staff was able to outline what action they would take when a person showed signs of anxiety. This required early intervention to keep them apart from other people living at the service by encouraging them to access their bedroom. We saw that staff had discussed the provision of 'emotional 'support' at a recent team meeting. Guidance had been provided by the manager which was specific to the needs of each person living at the service. In one case a flowchart had been produced which described how staff should respond if they were concerned about a person's low-mood.

We saw that people had choice and control over their lives and that staff responded to them expressing choice in a positive and supportive manner. With the exception of the administration of medicines, it was clear that the provision of care was not task-led and did not adhere to a fixed timetable. Staff and people living at the service told us that the provision of care was flexible and responded to people's changing needs. One person living at the service told us, "Staff would let me change my mind." When we asked people if they would be comfortable speaking with us one person said they would like a particular staff member to be present. The staff member stopped what they were doing and supported the person during our conversation. They encouraged the person to speak freely and showed respect for the person's views and comments.

Information was provided in a way that made it easier for people to understand. Staff took time to re-word things when people didn't initially understand. We saw that some important information, for example consent documents, were produced in plain English and made use of images to support people's understanding.

We saw evidence in care records that people had made use of independent advocates to represent them in legal matters. In relation to health matters, staff sometimes supported people to express their views. One member of staff said, "If they struggle with what they want to say [at medical appointments], we can step-in."

Privacy and dignity were protected and promoted by staff. Staff spoke with respect about the people living at the service and promoted their dignity in practical ways. A member of staff said, "We don't need to give people support with their personal care, but we do sometimes need to remind them." Another member of staff said, "It can be harder for male staff [to maintain people's privacy and dignity]." They gave us a practical example of how they did this in relation to cleaning people's rooms. Each person had a lock on their bedroom door for additional privacy and security. All confidential information was stored securely in an office within the service.

Friends and relatives were free to visit at any time. One of the people that we spoke with talked regularly with their friends. Another person said, "I've got an aunty who comes to visit. We go out together." An action had been developed from the most recent survey which encouraged staff to maintain family contacts and extend invitations to visit.

Good

Is the service responsive?

Our findings

We saw from our observations that the people living at the service were involved in discussions about care on a day to day basis. We also saw evidence that people were actively involved in regular reviews of their care. Each person had a monthly 'keyworker' review which was signed by the person and the staff member. Plans had been introduced for a more comprehensive, quarterly review of care plans and risk assessments. People also had annual reviews with health and social care professionals. Reviews were used to set goals and plan activities. For example, going out for meals or accessing computer training. One person living at the service told us, "I go over to the day centre every Friday and do computers every Tuesday. I do cooking and shopping and go to New Brighton." We saw that this was planned and recorded in care records.

We were not invited to see people's bedrooms, but saw that people's individual preferences and personalities were reflected in the decoration of shared areas of the service. The people living at the service were supported to follow their interests and an activities file was maintained which included photographs and comments from people living at the service. Activities were also discussed and planned at regular 'service user' meetings.

We observed that care was delivered only when it was needed. The people living at the service were encouraged to be as independent as possible and received staff interventions on request or when staff assessed that support was required. Staff knew their needs and preferences and responded with confidence when care or communication was required.

People told us that they had a choice over who provided their care. One person said, "I could refuse staff if I didn't like them." Another person told us, "I wouldn't mind if it was male staff [providing care] but I can choose."

The service had a complaints procedure available to people living at the service and visitors. Information on how to complain was provided as part of the service user guide and contained contact details for external organisations. We were told that no formal complaints had been received in the previous 12 months. One person living at the service said, "[if I had to complain] I'd speak to a solicitor or the staff. I've never had to make a complaint." The service also distributed surveys which gave people the opportunity to raise concerns. An action plan had been developed from the most recent survey which detailed a number of improvements and timescales for completion. For example, care plans, risk assessments and activities were to be reviewed more frequently. People were also supported to raise any concerns at the regular meetings with staff and the manager.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager in post. The current manager was in the process of applying to be registered. The manager was not available on the day of the inspection. The service was represented by an area manager. The area manager supported the inspection through the provision of information and the facilitation of discussions with people living at the service and staff. However, in the absence of the manager, they were unable to locate some of the information and records requested. For example, proof that references had been received for two people could not be provided on the day of the inspection. Proof that a gas safety check had been completed was not present in the service. This meant that the provider could not be certain that essential safety checks had been completed in accordance with their policy and legal requirements. The relevant documents were provided after the inspection. The area manager agreed to update the records stored within the service.

The provider had implemented an approach to quality monitoring which was appropriate for the size of the service. Monthly audits were completed which recorded important information about; financial performance, staff support and training. These audits identified a number of issues relating to safety and quality and showed evidence that they had been addressed in a timely and appropriate manner. For example, when a missing signature was identified on a MAR sheet, staff were spoken to about the importance of completing records accurately. However, these processes had failed to identify issues relating to the completion of essential safety checks and missing references. We also saw that records contained information about a person using a different service and some sections were not completed.

We recommend that the service reviews its procedures for auditing the safety and quality of the service to ensure that they are extensive and robust enough to identify all issues of concern.

The service also completed a range of health and safety checks on a monthly basis. However, checks were not completed after May 2016 because the service did not have a manager in post. This meant that people's safety may have been compromised during this period. We spoke with the area manager about this and were assured that the checks would be re-started as soon as the manager returned.

The service had been developed with input from the people living there and the staff team. Communication between staff and the manager was open and regular. We saw evidence that staff meetings had taken place regularly. Information relating to people living at the service and developments had been shared at the meetings.

The staff that we spoke with described the service's values in similar terms. Each said that the service promoted people's independence and kept them safe. We saw that these values were applied in communication with the people living at the service and in the delivery of care and support.

Staff were clearly motivated to do their jobs and enjoyed working at the service. One member of staff told us, "It seems like a brilliant house. I enjoy coming in." Another member of staff said, "I feel motivated. I enjoy my job." Staff understood their roles and demonstrated that they knew what was expected of them. The

manager maintained important information on staff files and electronic records and shared it with staff appropriately. Staff were required to sign to confirm that they had read and understood important information. Staff had access to other information, for example, policies and procedures. The policies that we checked were sufficiently detailed to inform staff about procedures and the standards expected by the service.

Records indicated that notifications of important events had been submitted to the Care Quality Commission appropriately. Safeguarding referrals to the local authority had been made in an appropriate and timely manner.