Care Quality Commission

Apna House Limited

Apna House

Inspection report

6 Park Avenue, Hockley, Birmingham B18 5NE
Tel: 0121 551 5678
Website: www.example.com

Date of inspection visit: 26 October 2015
Date of publication: 30/12/2015

Ratings

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

Overall summary

We received some concerns about the home relating to people not being cared for properly, poor management and concerns about the safety of the home. We brought forward our inspection of the service. This inspection took place on 26 October 2015 and was unannounced. At the last inspection on 06 May 2014, the provider was meeting the regulations we looked at.

Apna House is a care home which is registered to provide care to up to 13 people. The home specialises in the care of men who have mental health needs and a learning disabilities. On the day of our inspection there were nine people living at the home.

The home is required to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager had recently been appointed and was in the process of registering as the manager.

The provider had not always recognised when the care being offered had put restrictions on people's ability to make choices, and move around freely. Restricting people's freedom to move around without the necessary authorisation meant that the provider was not meeting

Summary of findings

the requirements of the Deprivation of Liberty Safeguards; therefore people's human rights were not protected. You can see what action we told the provider to take at the back of the full version of this report.

The provider had not always fulfilled their legal responsibility of notifying us of events or occurrences that had taken place in the service. This is so that we can where needed take follow up action. You can see what action we told the provider to take at the back of the full version of this report.

Staff understood the different types of abuse. The manager had ensured that the safeguarding systems in place were strengthened so that the procedures were consistently followed.

Risks to people had not always been well managed. Systems were in the process of being improved so that learning from incidents takes place, to ensure people's wellbeing and safety.

People were supported by adequate numbers of staff on duty.

People were supported to receive their medication as prescribed. Medicines were safely managed. Staff who administered medicines had received training in this.

Staff received the training and support needed and were supported by the manager so they could carry out their role effectively.

Staff were kind and compassionate in the way they supported people. People were supported to pursue interest and hobbies that were of interest to them.

People had access to food and drinks and were supported to have food that they enjoyed.

The provider had management systems in place to assess and monitor the quality of the service provided to people. However, they were not always effective at identifying where improvements were needed. The newly appointed manager had taken steps to ensure that the required improvements were made so that people were provided with a safe and effective care service.

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?

Requires improvement

The service was not consistently safe.

The risk of abuse and avoidable harm to people had been minimised because the systems in place had been improved.

Systems in place to assess risks to people had not always been effective.

People received their medicines safely.

Is the service effective?

Requires improvement

The service was not effective.

Arrangements were not in place to ensure that the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were understood and followed consistently.

Improvements had been made so staff received the support and training they needed to carry out their role.

People received food and drink to maintain their health and wellbeing.

Is the service caring?

Requires improvement

The service was not consistently caring.

The home had not always been maintained in a way that respected people's dignity and respect.

Staff knew people and what was important in their lives.

People were treated with kindness.

Is the service responsive?

Good

The service was responsive.

People could speak with staff if they needed to.

People were supported to follow their interests and hobbies.

Is the service well-led?

Requires improvement

The service was not consistently well led.

Systems in place to assess and monitor the quality of the service provided to people had not always been effective at identifying where improvements were needed.

The newly appointed manager had started to make the improvements needed so that people would be provided with safe and effective care.

Apna House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 26 October 2015 and was unannounced. The inspection team comprised of one inspector.

We looked at the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. Notifications are information the provider has to send us by law. We contacted the local authorities who purchased the care on behalf of people to ask them for information about the service and reviewed the information that they sent us. We received some concerns about people not being cared for properly, poor management and concerns about the safety of the home. We used this information to inform our planning.

During our inspection we met with all of the people that lived at Apna House. People living at the home have a learning disability and additional complex's needs. Some people had limited verbal communication and were not able to tell us if they liked living at the home. We observed how staff supported people throughout the inspection to help us understand their experience of living at the home.

We spoke with the manager, operations manager, and four care staff. We looked at the care records of three people, the medicine management processes and at records maintained by the home about recruitment, staffing, training and the quality of the service.

Requires improvement

Is the service safe?

Our findings

People we spoke with told us that they felt safe living at Apna House. They told us if they had any concerns that they would speak to staff of the manager. One person told us, “I have lived here a long time and I feel safe living here”. Another person told us, “I am fine living here. I do my own thing and I am happy spending time in my own room. If I need help I can ask staff ”

All the staff spoken with told us that they knew the different types of abuse. We saw records of incidents that had taken place in the home and the provider had not taken the appropriate action to report the concerns as required to CQC. However, since the new manager had been in post we saw that there had been improvements in sharing concerns with the local authority and CQC so that the safety of people could be monitored.

We saw that following an incident there had been no process in place to learn from the incident to ensure that people were being supported safely and appropriately. We saw that where people became distressed records were not made of the things that they were doing at the time. We spoke with the manager about this and we saw that work was in process to ensure that following an incident a review took place to ensure that people were supported in a way that promoted their safety, and that action had been taken to mitigate the risk of further incidents.

On the day of our inspection we saw that people did not have to wait for support from staff and there was enough staff to enable people to do things that they liked. A person told us, “There is enough staff here day and night”. Staff that we spoke with told us that adequate numbers of staff were available to support people. We asked the manager how they ensured that there was enough staff on duty. They explained how they managed the rota. They told us that there was a full staff compliment employed and to ensure consistency any unplanned staff shortages were covered by permanent staff and no agency staff worked in the home.

Staff told us that recruitment checks had been carried out prior to their employment. The manager told us that she had identified some gaps in staff’s employment records. We saw that action had been taken to ensure all the required information was in place, in line with the provider’s recruitment policy.

People told us that they received their medicines on time. One person told us, “I know what I am taking and I know what the tablets are for”. We saw that people had easy read information available to them about their medicines. This helped to provide people with a clearer understanding about the medicines they were taking and why.

We looked at the systems in place for managing medicines in the home and found that there were appropriate arrangements for the safe handling of medicines. We saw that staff recorded when people had been given their medicines. We saw that a person’s eye drops had not been dated when opened. This meant that staff would not be prompted to stop using them after 28 days as required to ensure they remained effective. The manager told us that this would be discussed with the staff team and that they were aware of the need to do this. We saw that checks on staff’s competency to give medicines safely were carried out to ensure their practice was safe. Arrangements were in place to ensure that people who could manage their own medicines were supported to do so.

Requires improvement

Is the service effective?

Our findings

Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty in order to keep them safe.

During our inspection we saw that restrictions were in place for a person, this included close supervision by staff at all times. No application had been made to the supervisory body for authorisation to restrict the person in their best interest. Staff spoken with had some understanding about the principles of Deprivation of Liberty Safeguards (DoLS) and told us about a person who did have a DoLS in place. However, the training staff received had not been effective to support them to recognise when people's liberties were restricted. We had not been notified of the DoLS application that had been approved. Effective systems were not in place to ensure that the legislation was properly applied by the provider. This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people that lived at the home may not have the mental capacity to make an informed choice about some decisions in their lives. Throughout the inspection we saw staff cared for people in a way that involved them in making some choices and decisions about their care. For example, we heard staff ask people what they wanted to do and how they wanted to spend their time. We saw staff offer people choices about what they wanted to eat and drink. However, we saw that the provider had not always ensured that when a person lacked capacity to consent to bigger decisions about their care or treatment the provider had not always taken steps to ensure that the decisions were made in the person's best interest. For example, a person had refused to attend a medical appointment and it was not clear how the person had been supported with this decision.

Staff told us that the recent management changes had a positive impact on the home. Staff said they felt supported by the new manager. A staff member told us, "Since the new manager came we are really getting on top of things. We have had meetings and staff supervision. I feel much more supported. We are updating any training that we need to do". Another staff member told us that they were being supported to undertake NVQ level 5 to enhance their knowledge and skills.

We saw that staff worked as a team when they identified that someone was becoming upset or distressed. We saw that staff worked together to support the person and reduce their anxiety. They ensured that the person was supported to do an activity that they enjoyed and this helped the person to relax and to become less anxious.

All the people we spoke with told us that they liked the food. We saw that people had access to a kitchen to make drinks and snacks. Menus were planned and had considered people's known preferences, religious and cultural needs. One person told us, "The food is good". Another person told us that they were eating a bit later and the chef was preparing food that they had specifically asked for.

People told us that they were supported to see a range of health care professionals. For example dentist, opticians and GP. Staff told us that they understood people's specific healthcare needs and they told us that they knew when to share their concerns with the manager and when to seek professional advice. We saw that the outcome of some healthcare appointments were not always detailed in people's records including reasons for missed healthcare appointments. We discussed this with the manager during our inspection. She had recognised that some improvements were needed to the recording in care records to ensure that people's healthcare needs were being monitored effectively.

Requires improvement

Is the service caring?

Our findings

Some people invited us to look at their bedrooms. All the bedrooms and bathrooms we saw had not been well maintained. Bedding, flooring and the general up keep and maintence was in a poor condition. We could see that work was underway to improve the whole environment and the manager confirmed to us the planned refurbishment that was taking place. However, these living arrangements had not ensured that the provider had upheld and respected the dignity of the people living in the home.

One person told us, “I feel listened to. I am quite happy living here”. Another person told us, “I am alright with things here. I am happy living here”.

We spent time in the communal areas of the home and observed that the interactions between people using the service and staff showed that they had a good relationship. We saw that staff included people in conversations. When a person returned after being out for the day staff spoke with them about their day.

Throughout our inspection we observed staff working consistently in a respectful way. We saw that staff knew people well and knew when people were becoming anxious. Staff took action to reassure and involve the person in an activity that they enjoyed.

People had their own bedroom so that they could spend time in private if they choose to. One person told us, “I prefer to spend time in my room. Yes staff do knock on your door. I have my own key”. We saw that staff spoke to people respectfully. We saw that staff knocked on people’s doors and waited to be invited in to people’s bedrooms before entering.

Staff explained that they do try to encourage people to be involved in making decisions about their care and promoting people’s independence. One person told us that they looked after their own bedroom and carried out some cleaning tasks. Another person told us, “I do the sweeping at the front of the house. I also go shopping but I do not do any cooking”. We saw that people had some input in the day to day running of the home and some opportunities to develop their self-help skills, although our observations on the day indicated that this was limited. The manager told us that she was looking at ways of ensuring that people were more actively involved in making decisions about their care and support and their involvement in day to day chores and activities. This included looking at ensuring regular meetings take place with people to ask their views about the home.

Good

Is the service responsive?

Our findings

All the people we spoke with told us that they were satisfied with how their needs were being met. One person told us, “I can do what I want. I get up when I want. I feel safe and the staff understand me”. Another person told us, “The staff ask me how I am, I am happy with everything”.

Staff were able to tell us about people’s individual needs, interests and how they supported people. Staff were aware of the person’s preferences and knew how to respond to the person’s needs. They told us that communication between staff was good and they were informed about any changes in people’s care that they needed to know about. Staff told us that they would report any changes in people’s needs to the manager.

One person told us, “I like reading, I go to the library. I enjoy watching crime programmes on the television. The staff help me with managing my finances”. Another person told us, “I like to go to the social club with one of the staff. I go out in the car and for walks”. We saw that activities were based on what individuals liked to do. The home had its own car and it was used by the people that lived there and enabled them to access community activities and to go shopping. We saw that one person engaged very little with staff and the other people that they were living with, and staff told us and records showed that their social activities were limited. The manager told us that they had recognised this and would be supporting the person to explore possible interests and hobbies.

People told us that they attended meetings to talk about what they wanted to do and plans for the home. One person told us, “'I am getting a lockable cupboard for my room”. Records confirmed that these meetings took place and the topics discussed included informing people about the new manager, and the redecoration work and replacement of some furniture that would be taking place over the next few months.

We saw that questionnaires and surveys had been completed with people to ask their views about a range of things including activities they enjoyed, their favourite take away food and television programmes that they liked to watch. This information was used to improve the home. We saw that information about the home was provided to people in easy read versions and had also been translated into different languages so that the information was accessible and meaningful to people.

People told us they knew how and who to complain to. One person told us, “I would speak to the manager or any of the staff”. Another person told us, “I would speak to the staff if I needed to”. One person told us about the banging of bedrooms doors which disturbed them at night. Another person told us that some times the back door was locked at night and they were not able to go outside after this time for a cigarette in the smoking area. We spoke with the manager about the issues that people had raised and she confirmed to us that these had been dealt with to the satisfaction of both people. The manager told us that an easy read version of the complaints procedure had recently been introduced to people. She told us that prior to her employment, no complaints from people had been recorded in the home’s complaint records. However, she told us she would be exploring with people and staff how niggles and informal complaints from people will be captured, recorded and dealt with in a more effective way.

Requires improvement

Is the service well-led?

Our findings

Organisations registered with CQC have a legal obligation to notify us about certain events, so that we can take any follow up on any action that is needed. Recent incidents that had occurred prior to the new manager's appointment had not been notified to us. The provider had not fulfilled their legal responsibility. This included notification of DoLS approval and notifications of safeguarding incidents that had occurred in the home. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

A new manager for the service was appointed in October 2015 and had been in post only a few weeks before our inspection took place. They were also the registered manager for one of the providers other services that was located nearby. They were in the process of applying for registration and would be the registered manager over both services.

We saw that there were some systems in place to monitor the quality of the service, and quality audits were undertaken. This included audits of medicine management, care records, health and safety and accident and incidents. We saw that that prior to the manager's appointment these audits had not been effective in identifying the shortfalls and the breach of the regulations we found during our inspection. The providers systems had not identified when peoples' liberties were being restricted and we had not been informed of all incidents that affect the health, safety and welfare of people that use the service. There had been no analysis of incidents and accident records so that themes and trends could be identified and steps could be taken to minimise the likely hood of a reoccurrence. However, we saw that in a short period of time the manager had started to take action to ensure that the service met the requirement of the regulations. More robust audits had been introduced and these had identified where improvements were needed. The manager had implemented action plans so it was clear what would be done and when.

We saw that the manager was visible in the home. We saw throughout our inspection that the manager led by example guiding and supporting staff and modelling a positive response to people's needs. All the staff that we spoke with were positive about the new manager. A staff member told us, "I am very happy working here. We work well as a team". Another staff member told us, "The new manager is fair and very professional. Things are really improving". All the staff told us that the manager was very approachable and that they could speak with her at any time. They told us that regular staff meetings were being introduced. They told us that the manager was ensuring that they were clear about their responsibility to ensure the safety and wellbeing of the people living at the home. For example, a staff member told us that the reporting and recording of incidents had improved. Another staff member told us that work was taking place to improve the physical standards of the home so it was a nicer place for people to live in.

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 **The provider had not ensured that an effective system was in place to prevent people being deprived of their liberty.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The provider had not ensured that CQC were notified of all events or occurrences that must be notified so that where needed CQC can take follow- up action.**