Metropolitan Housing Trust Limited

Burwell

Inspection report

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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?	Good

Summary of findings

Overall summary

Burwell is registered to provide accommodation and personal care to up to eight people. The people living at the home have learning disabilities and may also have physical disabilities. The home is arranged in two bungalows and situated in a residential part of a Cambridgeshire village. At the time of this inspection care was provided to seven people.

This comprehensive inspection took place on 13 September 2016 and was announced.

The provider is required to have a registered manager as one of their conditions of registration. A registered manager was not in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the agency. 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 manager had been in post since mid-July 2016 and was applying to be the registered manager.

People were kept safe and staff were knowledgeable about reporting any incident of harm. People were looked after by enough staff to support them with their individual needs. Pre-employment checks were completed on staff before they were assessed to be suitable to look after people who used the service. People were supported to take their medicines as prescribed and were enabled to be independent with this if they were safe to do so

People were supported to eat and drink sufficient amounts of food and drink. They were also supported to access health care services and their individual health and nutritional needs were met.

The CQC is required by law to monitor the Mental Capacity Act 2005 [MCA 2005] and the Deprivation of Liberty Safeguards [DoLS] and to report on what we find. The provider was aware of what they were required to do should any person lack mental capacity. People's mental capacity was assessed and care was provided in their best interests. Staff were trained and knowledgeable about the application of the MCA.

People were looked after by staff who were trained and to do their job. However, staff morale was low and the manager was aware of this. They were taking action to remedy this situation. Staff were now receiving one-to-one and group supervision.

People were treated by kind, respectful staff who they liked and they were enabled to make choices about how they wanted to live. People and their relatives were given opportunities to be involved in the review of their individual care plans.

People were supported to be part of the community; they were helped to take part in recreational and work-related activities that were important to them. Care was provided based on people's individual needs. There was a process in place so that people's concerns and complaints were listened to and these were acted

upon.

The manager was supported by a team of management staff and care staff. There was a high usage of agency staff and there had been four different managers in the last 12 months. The staff considered that these two factors had a negative impact on their morale and effective team work. The manager had identified these issues and was taking remedial action to resolve these concerns.

Staff, people and their relatives were able to make suggestions and actions were taken as a result. Quality monitoring procedures were in place and action was taken where improvements were identified.

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's individual needs were met by sufficient numbers of staff.

People were kept safe as there were recruitment systems in place to ensure that prospective employees were suitable to safely look after people.

People's medicines were safely managed.

Is the service effective?

Good

The service was effective.

The provider was acting in accordance with the Mental Capacity Act 2005 legislation to protect people's rights.

Staff were trained and were being supported to enable them to meet people's individual needs.

People's health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were looked after by kind and attentive staff.

People's rights to independence, privacy and dignity were valued and respected.

People were involved and included in making decisions about what they wanted and liked to do.

Is the service responsive?

Good

The service was responsive.

People's individual physical and mental health needs were met.

People were supported to take part in activities that were important to them.

The provider had a complaints procedure in place. This enabled people and their relatives to raise their concerns and these were responded to, to the satisfaction of the complainant.

Is the service well-led?

Good

The service was well-led.

People were enabled to make suggestions to improve the quality of their care.

The safety and quality of people's care was monitored and kept under review.

The management of staff ensured that people benefited from safe and appropriate care.

Burwell

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 13 September 2016 and was announced. It was carried out by one inspector. The provider was given 24 hours' notice because the home is small and we needed to be sure that someone would be in.

Before the inspection we looked at all of the information that we had about the service. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law.

During the inspection we spoke with three people and one relative. We also spoke with the manager; one team leader; three senior members of care staff, one of whom was also the activities co-ordinator; one member of care staff and four agency staff members.

We looked at three people's care records, medicines administration records, records in relation to the management of staff and management of the service. We also looked at records of audits that had been carried out by the manager.

Due to their complex communication needs some people were unable to tell us about their experience of being looked after. Therefore, we observed care to assist us in our understanding of the quality of care people received.

Good

Is the service safe?

Our findings

We saw that people were comfortable and at ease. This was during the times staff were helping or talking to them. The relative told us that their family member was safe because staff treated them well.

Procedures were in place to keep people safe from the risk of harm. Staff were trained and knowledgeable about their roles and responsibilities in keeping people safe. They demonstrated their knowledge regarding the types of harm, including financial, psychological and physical harm. Staff were aware also of the signs and symptoms that people might show if they were being harmed. One senior member of care staff said, "If a person was being harmed, they could become withdrawn. Or have (unexplained) bruising." The members of staff knew who to report to any concerns. They said this would be to their manager or CQC, the police or the local safeguarding authority.

The provider had submitted notifications to us when there were occasions of people being placed at risk of harm. The information detailed in the notifications told us that appropriate actions had been taken to protect people from the risk of recurring harm. This included the retraining of staff in the management or people's medicines

We checked and found that people were looked after by sufficient numbers of staff. The relative told us that they were aware of the shortage of permanent staff but believed that new staff were being recruited. On the day of our visit it was the first working day of a newly recruited member of permanent care staff. We saw people's needs were met by sufficient staff. This included being able to go out into the community with staff escorts and being helped with their food and drink in an unhurried way. People had their morning medicines as prescribed.

The manager told us that the staffing of the home was a problem. This was due to the lack of permanent staff and the high use of agency staff. They said, "The major problem is staffing. We are quite stretched staffing wise." They also said that there was an on-call out-of-hours system which enabled staff to contact the management team. This had been used so that both the manager and team leader had worked extra to cover staff shortages. Waking night staff were provided to support one person's individual night-time needs to keep them safe. The manager advised that this was often a member of their own bank staff.

We found that some of the agency staff had worked a number of times at the home and knew people's needs. The team leader said, "Most of the time they [agency staff] are regular. We have some very good agency staff who come here a lot. They are very proactive. They don't wait to be told what to do. They know the support plans very well. And I'm very comfortable to assign them tasks which I assign to regular staff." One senior member of care staff said, "There are some agency staff who do keep coming back and are really good." Agency staff, who had previously worked at the home, demonstrated their knowledge about people's needs. For example, we saw an agency member of staff offer the person, who they were looking after, choices of what they liked to do. Some of the people preferred to be looked after by staff who were familiar to them. We saw people were comfortable, at ease and being well-looked after by both agency and permanent staff.

At the time of our visit two agency staff were new to the home. They told us that they were being advised what they were to do. We saw senior members of care staff direct these two agency staff in what they were to do and monitored how they were working. This included, for example, supporting a person with a thickened drink of squash. The manager advised us that recruitment arrangements of permanent staff were in place. These included interviews of prospective staff which were planned to take place during September 2016.

Recruitment procedures were in place to ensure people were looked after by suitable staff. The manager described their recruitment process, which included attending an interview. They also told us that all the required checks were in place before they were allowed to start. A member of care staff also told us about their recruitment process and the required checks needed. They said, "I had an interview with two senior people. They went through some questions with me. I had a DBS [Disclosure and Barring Service police check]. I filled out a health questionnaire and I filled out an application form before the interview. My last employer and a previous employer gave references."

People's risks were assessed and measures were in place to mitigate the risks. Staff members were aware of keeping people safe from harm. One senior member of care staff said, "People need to do things. If people say 'it's too risky' nothing will happen." They gave an example of supporting people to and from a swimming pool by means of equipment. This was to reduce the risk of falls on uneven and wet flooring. We found that risk assessments were recorded and measures were in place to mitigate the risk. For one person they were assessed to be at risk when they went swimming. Measures were in place for the person to be supported by staff members who were trained in emergency first aid. Training records demonstrated that the person was supported to go swimming by a member of senior care staff who was trained in this subject. People had individual risk assessments in place to guide staff in what action they needed to take in the event of a fire.

People's other risks were assessed and measures were in place to manage the risks. One of these included, for example, risk of choking. Action was taken to soften people's food and thicken their drinks so that these could be swallowed safely. Another risk was for when people went out into the community. To ensure the safety of people when doing so, they were escorted by at least one staff member to keep them safe from harm.

We found that the management of people's medicines had been of a concern but action was taken to improve the safety of this. The provider had carried out an audit of the management of people's medicines and found that people were being placed at risk. The manager told us that they had analysed the cause and found that this was due to ineffective training of staff. As a result of their findings, they had made arrangements for staff to attend further training in the management of people's medicines. They said, "Most issues were about a rare occasion of a tablet being missed [i.e. not given]. Most cases the medicines sheets [records] were not being signed. When I spoke to staff it was clear they were not enabled by the training they had. So I organised that all staff went on the Cambridgeshire County Council [CCC] medication training." This training has been arranged to take place during October 2016.

Senior members of care staff also attributed medicines errors when there was insufficient trained numbers of staff to help people with their medicines. One senior member of care staff said that errors occurred because they felt "rushed." The manager agreed, from their experience of administering people's medicines, that this was an added pressure for staff. We checked people's medicines administration records [MARs] and found that people were given their medicines as prescribed. The relative told us that their family member had their medicines as prescribed and this included during stays at the family home.

We found one person was not given their medicines as prescribed on one of the days during September

2016. The team leader described the reporting actions they had taken and this was supported by records. The reporting actions were to the GP and local safeguarding authority. The team leader advised us, and the person's records showed that the person experienced no ill-effects which could be directly attributed to the medicines error. Two team leaders told us that they found that the errors were mainly due to missed signatures on people's MARs and lack of labelling of containers of people's medicines. An audit had been carried out and this demonstrated that remedial actions were taken to improve the safety of the management of people's medicines

The manager told us that staff were assessed to be competent in the management of people's medicines. They said, "The ones [members of staff] who have made mistakes have been reassessed. If they do make mistakes we do not allow them to administer medication until they have had their competencies reassessed." They also told us that agency staff do not administer people's medicines but when they did, they were trained and assessed to be competent in their practice. Training and competency assessment records confirmed that staff were trained and assessed to be competent in the management of people's medicines.

Good

Is the service effective?

Our findings

The 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in registered services are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

During our last inspection of 10 November 2015 we found that the provider was not ensuring that people were protected from unlawful care. This was because their mental capacity to make decisions had not been assessed. The provider wrote to tell us what remedial action they intended to take and this would be completed by no later than 27 May 2016.

At this inspection of 13 September 2016 we found that the provider had followed their action plan to meet the shortfalls. This included the completion of assessments of people's ability to make informed decisions about their personal care and medicines. People's preferred communication methods were used during the assessment process. This included, for example, the use of pictures. Furthermore the manager told us that advice had been sought from an employee of CCC about what they needed to do. They said, "DoLS applications will be made very soon. But I want to be sure that all the information in the support [care plans] provides the proper evidence to go with the DoLS applications." These findings showed that the provider had made improvements and was aware of their responsibilities in keeping people safe legally.

Staff were trained or were to be trained in the application of the MCA. One senior member of care staff demonstrated their knowledge gained from their training. They said, "The MCA is to assume that people have mental capacity unless proven otherwise." They also told us that they had been to best interest meetings. This was attended also by the person that the meeting was about, health care professionals and relatives. The meeting was held to determine if a proposed surgical operation would be in the person's best interest. Another senior member of care staff described their understanding of best interest decisions. They said, "If the lack of care is detrimental to a person's health, there is a multi-disciplinary decision for them. This is, for example, for a person to have their medication in their best interest." We saw one person had their medicines disguised in food or drink and this was based on a best interest decision.

People were having their needs met by staff who were trained to do so. Staff told us that they had attended training in the application of the MCA, safeguarding, moving and handling and food hygiene. Training records showed that staff had attended such training. Where staff had not attended training the records showed that they were 'enrolled' to up-date their knowledge in looking after people. In addition to this, there was induction training for new staff. The member of care staff said, "I'm shadowing [watching more

experienced staff at work]. And looking around the building. Knowing where the fire exits are. Reading the care plans and policies. I am happy to start work here and getting to know the residents [people] and staff."

People benefitted from being looked after by staff who were being supervised. The manager told us they had noted that an improvement was needed in staff's understanding of people's communication needs. They said, "I had to deal with staff understanding of people's low-level challenging behaviours. Such as grinding their teeth or toppling over chairs. Some staff perceived this as being provoked and it was being done deliberately. This has now stopped." This was because staff were now aware that these types of actions were signs of how the person was communicating about how they were feeling.

The manager told us that they had carried out one-to-one or group supervision of staff. The supervision included a two-way discussion regarding the members of staff's training and development needs and work-related matters. Staff told us that they had attended such supervisions. However, they said that they felt there was a lack of support from the management and team. One senior member of care staff said, "There is no team here." "Another member of senior care staff said, "We used to have such a brilliant team. Now it is so fragmented. I've got to the point that I don't think I can make a difference anymore [to people's lives]. " A third member of senior member of care staff said, "When I first started here [over three years ago], there was a lot more team work. It's just not having enough permanent staff." The high use of agency staff, lack of permanent staff and lack of permanent managers contributed to staff feeling the way that they did. The manager told us that they had identified that staff morale was low and was taking action so that staff felt more supported. This included, for example, team building exercises and recruitment of permanent staff.

We checked and found that people were helped to maintain their nutritional health. The relative told us that their family member always had enough to eat and drink. People were helped to make choices of what they wanted to eat. This was by verbal, pictorial or visual methods of communication. One senior member of care staff described how this was carried out. They said, "[Name of person] will be given two things [to eat] to choose from. It is how they focus [their look] that indicates their preference." Another senior member of care staff said, "Pictures are used for menus." They added that it was how people communicated, which included verbal or non-verbal gestures and signs that helped staff know what the person wanted to eat and drink.

People's daily care records demonstrated that people had a varied diet. Based on nutritional risks, people's food and drink intake was monitored and recorded. One senior team leader told us about one person who was at such risk. They said, "[Name of person] doesn't always eat or drink well, so we have a chart of what [they] have. [They] ate really well their breakfast today." People's food and drink monitoring records showed that people were having enough to eat and drink. We saw that staff helped people with their food and drink unless they were independent with this.

People's mental and physical health care needs were met by a range of health care professionals. One senior member of care staff told us that recently people had their eyes checked and records confirmed this was the case. People were helped also to attend GPs and to have their feet treated by chiropodists. Care records demonstrated that people were helped to gain access to speech and language therapists, community based occupational therapists, dentists and psychiatrists. One team leader gave an example of how one person's mental health had improved. This was due to a psychiatrist's review of and change in the person's prescribed medicines. The senior member of care staff said, "[Name of person] is a lot calmer than they used to be."

People's sense of well-being was maintained. The manager said, "I see that the clients [people] are happy and comfortable." They gave an example of a person's achievement in voluntary work and said, "It's so good for [their] self-esteem."

Good

Is the service caring?

Our findings

We found that people were being looked after by kind and caring staff who respected people's rights. The relative told us that the staff were kind and caring to their family member. It was clear that people were helped by staff to make day-to-day decisions about how they wanted to spend their day. We saw a member of agency staff ask a person what they liked to do, which included listening to music and having a drink at a local pub. During their meetings people were offered choices of what they liked to do, which included activities that they wished to take part in. This included swimming, going for a walk and shopping.

People's choice of how they wanted their home decorated was valued. One member of senior care staff described how this was carried out. They said, "They [people] had a house meeting and had colour charts and could point to, or look at, what colour they wanted. It is their house." A communal lounge and showering/toilet facilities had been decorated based on people's colour choices.

People's right to independence was promoted and maintained with a range of practices. This included independence with making a snack and drink with support from staff members. Photographs and care records provided evidence that, where possible, people were encouraged to practise other independent living skills. These included, for example, taking their clothing to the laundry room to be washed and cleaning duties. People's level of independence with their eating and drinking was also maintained and promoted.

The home maximised people's privacy. All rooms were for single occupancy and toilet and bathing facilities were provided with lockable doors. The premises also maximised people's dignity as all bedrooms were individually decorated and furnished.

People were helped to maintain contact with members of their family. The relative told us that their family member visited them every week with the help from members of staff. They told us also that their family member was treated with dignity. This was because they were helped to maintain their personal hygiene and were well-dressed in clean clothes.

Members of care staff had an understanding of the principles of good care. One senior member of care staff said, "My job is to make sure people are enjoying their life and have a nice time. And do the things they want to do. Some of the residents [people] we can ask them what they want to do. Some we show them pictures. You can see what they are saying." We saw an example of this recorded. In one person's care records their non-verbal communication signs showed that they chose to go swimming and was looking forward to it.

Information about general advocacy services was available. Both the manager and team leader were aware of these services but said none were being currently used. Advocacy services are organisations that have people working for them and who are independent and support people to make and communicate their views and wishes.

Good

Is the service responsive?

Our findings

People's individual physical and mental health needs were met. The relative told us that their family member's continence needs were well-managed. They also added that they had no concerns about how their family member's emotional well-being was maintained. They said, "[Family member] is fine. [They] can get quite agitated but when I have seen [them] they have been happy." Moving and handling equipment was provided to help people with their mobility needs. The equipment used included over-head tracking and mobile hoists.

To maintain people's self-esteem and well-being there was a range of activities which people took part in. Staff supported people to visit museums; go on boat trips; visit local country parks; go for walks and cycle rides; and go shopping and swimming. The relative said that there was an improvement in the range of activities that their family member took part in. The manager said, "What's good about here is that people are very active. They are always busy." On the day of our visit people were taking part in various activities. These included having aromatherapy; going out for a walk; going to do voluntary work and visiting a botanical garden.

One senior member of care staff showed us vegetables growing in one of the home's gardens. They told us that staff had helped people with this gardening activity. Minutes of a meeting showed how people took part in a 'tasting' activity. This was when people tasted different types of food and was part of a group exercise. The team leader compared the provision of activities of two years ago to now. They said that there was a "massive improvement" in the range of activities which people were now able to take part in.

People's right to be included in planning and reviewing of their care was valued. The relative told us that when their family member's care was reviewed they were invited and attended the meeting. They added that their family member also attended the review. The manager told us that reviews of people's care were yet to be carried out. However, they advised that when these were to take place, the person and their relatives would be invited to attend.

People were protected from the risk of receiving inappropriate care. This was because their care plans and risk assessments were kept under review by management staff. People's care plans and risk assessments were up-to-date. This was to provide staff with the guidance in how to meet people's needs. The care records also contained details about people's individual life histories. Staff members demonstrated their knowledge about people's individual needs. This included knowledge about people's family histories and their individual communication and behavioural needs.

There was a procedure in place to listen and respond to people's complaints. The relative said, "If I had any concerns I would just pick up the 'phone. The contact there [the home] is very good. There is always someone to talk to." They said that when they had any cause to raise a concern, they felt listened to and not judged. One senior member of care staff told us that if they had received any concerns, they would report them to the manager.

The manager told us about what remedial action they had taken in response to complaints. They gave an example of purchasing ironing equipment to improve the presentation of people's clothes. They gave another example of improving communication and relationships between staff and one of the people's relatives.

Good

Is the service well-led?

Our findings

There was no registered manager in post at the time of our visit. The manager started their job during July 2016. We heard from various members of staff that the manager was "approachable" and "a nice person." The relative told us that they knew that there was a new manager in post. The manager told us that they were applying to be registered with the CQC.

Before the manager started the provider had interim management arrangements in place. One senior member of care staff said, "We've had a lot of managers here. About four in the last year. It's unsettling because of the changes in the ways of working." Another senior member of care staff told us, "There has been a lack of consistency [in management of the home]." A third senior member of care staff said that they would like to see more of the current manager walking around the home, rather than be predominantly office based. However, they were aware of the improvement actions need to be taken by the manager. Nevertheless, the manager stated that they had worked extra to cover staff shortages, which included administering people's medicines.

Since the recent start of their job the manager had identified areas for improvement and actions were taking place. These areas included the recruitment of permanent staff and reduction of usage of agency staff; improving the management of people's medicines to reduce the numbers of errors; the enrolment of members of staff to attend training to protect people from unsafe and inappropriate care; and to improve staff morale and promote the spirit of team working. These actions were as a result of the manager's internal audits and external audits carried out by CCC employees.

The manager had also made another improvement action with the re-introduction of staff meetings. This enabled staff to review people's individual care needs. One senior member of care staff said, "[The manager's] meetings have been better than the previous managers'. Because they have been held about every two weeks and they are about the residents [people]. It's brilliant." Another member of senior care staff told us that equipment was being purchased based on what staff had suggested during one of these meetings. This was to improve the comfort and safety of one person's seating arrangements. Minutes of the meetings demonstrated that people's needs were reviewed and discussed to ensure that their planned care was meeting their individual needs.

People were provided with opportunities to influence how they wanted to be looked after. Minutes of their meetings showed that people were involved and included in making decisions. These were, for instance, choices about the activities and colours of paint to redecorate parts of their home.

Audits were carried out in relation to people's care plans. The team leader told us that these were almost completed. Another auditing process included that for people's prescribed medicines. Actions were identified and signed off as completed.

We found that the provider was aware of their legal responsibilities. This was because we have received notifications as required. The team leader was aware of when CQC should be notified and had submitted

such notifications. This demonstrated that the provider had an understanding of their legal responsibilities.

Members of care staff were aware of the whistle blowing procedure. One member of senior care staff said, "Whistle blowing is reporting something that is not right. If I turn a blind eye, I would be guilty as the rest." Another senior member of care staff also added that they knew that the whistle blowing policy was to protect them from any reprisal.

There were links with the community so that the provider was able to demonstrate their openness and transparency of looking after people. The activities co-ordinator said about the local people, "They are pretty friendly here. When we go out people say 'hello' to us." Other community links included people going out and about to local shops, visiting towns and cities and working in a voluntary capacity.