Sense

SENSE - 296-298 Warren Farm Road

Inspection report

296 -298 Warren Farm Road
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Ratings

Overall rating for this service	Requires improvement
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

Overall summary

This report provides details from two separate inspection visits which took place months apart. The first inspection was in April 2015 and the second inspection visit was in November 2015. We were unable to provide a report from the first visit but felt it valuable to provide summaries of both visits together with the judgements from the most recent inspection visit in November 2015. Both visits were unannounced. Prior to the April visit we had last inspected this service in March 2014 when the service had met regulations.

The home provides accommodation, care and support for up to five people with learning disabilities, physical

Summary of findings

disabilities and sensory impairments. People in this home were unable to tell us verbally about the care that they received so we observed how care was provided to people.

The registered manager had formally left the service in July 2015 but had yet to apply to cancel their registration with us. 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 line manager, (the area manager for the service), was managing the service on both of our visits in April and November 2015. We were told that a person had been identified to take over as a permanent manager and checks were currently being undertaken.

People were kept safe from the risk of harm. Staff knew how to recognise signs of abuse and who to raise concerns with. People had assessments which identified actions staff needed to take to protect people from risks associated with their specific conditions and they administered medicines appropriately.

People were supported by the number of staff identified as necessary in their care plans to keep them safe. However there had been significant number of changes in the staff that provided the care and relatives told us that they were concerned about this and had reported their concerns to the management team. There were robust recruitment and induction processes in place to ensure new members of staff were suitable to support the people who used the service.

Staff we spoke with had the skills and knowledge to ensure people were supported in line with their care needs and good practice. They told us that they had received support and guidance to ensure people received the best care.

Staff sought consent from people before providing any care or undertaking any tasks using the individual person's preferred method of communication. Applications were made to the appropriate local authority where people did not have the capacity to make decisions about their care and treatment for their authorisation. We had not been informed before the inspection that one of these had been authorised as required.

When necessary, people were supported to eat and drink and access other health care professionals in order to maintain their health. However staff were not consistently showing that systems to ensure food was safe were being adhered to.

On both of our visits staff communicated with people well and people showed by their expressions that they were happy with the care they were receiving. However relatives were concerned about the amount of staff changes there had been. We saw evidence of this in the complaints book we could not find a response from the provider to these complaints.

People's care plans were changed when their needs changed so staff had up to date instructions to follow. People were involved in a range of leisure activities some individual to them and some in groups. Although there were systems in place for handling complaints – that was not consistently applied, expressions a smaller concerns were not being managed and responded to consistently.

We had received a number of concerns about incidents in the home, the investigation process and ability of staff to raise concerns. Although staff we spoke with told us that there had been improvements in this we have continued to get concerns raised. This indicated to us that the management had not ensured that there was an open effective and safe environment for existing staff and relatives to be heard. Some systems were not identifying short falls in recording or changes in people's health that needed investigating which meant that the service was not able to learn from or reflect on what was working well and what needed to improve.

The issues noted related to a lack of consistent management oversight and handling of day to day issues. The systems in place to assess, monitor and improve the quality of the service that the provider had in place had not been consistently used. In some instances where action had been taken to address issues the action taken had not been comprehensive and this had resulted in only partial solutions. You can see what action we told the provider to take at the back of the full version fo 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 safe.

Staff were clear about their responsibility to take action if they suspected a person was at risk of abuse.

There were enough staff to keep people safe from known risks.

Medicines were safely administered and stored.

Good

Is the service effective?
The service was effective.

There were appropriate numbers of staff with the skills and knowledge needed to meet people's specific care needs.

People's rights were protected as staff gained people's consent before people had care and treatment or that best interest decisions are authorised in line with the law.

People were supported to eat and drink enough to maintain their well-being and people had access to health professionals when needed.

Good

Is the service caring?
The service was caring.

Staff communicated effectively with people and observations showed that people were happy with the care they received.

People appeared physically well cared for and arrangements were in place to respect people's privacy and dignity.

Good

Is the service responsive?
The service was responsive

People were supported to maintain contact where possible with people who were important to them. They were encouraged to be involved in interests and hobbies as much as possible.

There were systems in place to assist relatives to raise concerns or complaints. The outcomes of concerns raised were not always recorded.

Good

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

Requires improvement

Summary of findings

The systems in place to assess, monitor and improve the quality of the service that the provider had in place were not consistently used. The culture of the was not open and transparent to enable improvements and developmenst to be identified and acted on.

There was a lack of consistent oversight of systems in place, information was not always available when needed.

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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.

Our last inspection took place in March 2014 when the service met the regulations that we inspected. This inspection took place over two visits. The first visits was on 16 & 17 April 2015 and the second on 9 November 2015. We were unable to provide a report from the first visit but felt it valuable to provide summaries of both visits together with the judgements from the second inspection visit. Both visits were unannounced. The first visit was carried out by one inspector and the second visit by two inspectors.

We reviewed all of the information we held about the home. This included statutory notifications received from the provider about accidents and safeguarding alerts. A notification is information about important events which the provider is required to send us by law. When we returned for our second visit in November we reviewed the information we had obtained at our first visit in April. This helped us to identify if the provider had taken action in response to feedback given at our first visit.

People who lived in the home did not communicate verbally due to their health conditions, so we spent time at both visits observing people's care in the communal areas of the home and we used the Short Observational Framework for Inspection (SOFI) on our second visit. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with one relative and two social care professionals involved in people's care. Over the two visits we spoke with six staff members and we spoke to the acting manager on both visits.

At our first visit we looked at parts of two people's care records and at the second visit we looked at two people's care records. We also looked at other records that related to people's care. This was to see if they were accurate and up to date. We also looked at medication records, staff employment records, quality assurance audits, complaints and incident and accident records to identify the provider's approach to improving the quality of the service people received.

Good

Is the service safe?

Our findings

At both our visit in April 2015 and in November 2015 staff spoken with knew of their duty to report any concerns about the care of people. They were aware of the agencies who may be involved investigating any allegation of abuse and would further report to these agencies if they continued to have concerns after they had spoken with managers. In November 2015 one staff member told us: "I know if I raised concerns [about people's care] with the managers it would be dealt with." We saw a notice showing that the provider had planned refresher training in safeguarding shortly after our inspection.

Some concerns had been raised with us and the provider before our visit in April and these had been investigated by either the local safeguarding authority or by the provider. Where this resulted in recommended actions to improve the safety of people or to ensure that people received non-discriminatory service we saw that some action had been undertaken. The provider told us of another incident following our visit in April 2015 and this was investigated and action was being taken to minimise the risk of any misunderstandings of what was appropriate staff conduct.

In April and November 2015 visits we saw that the risks to people had been assessed and plans put in place to minimise risks of harm. For example, there were risk management plans for people who were able to move independently with support. During our observations over both our visits we saw that people had the support needed to move independently and that staff followed the instructions in the individual risk management plans to support people safely. However there was little cross referencing of information available to identify any linked issues, minimise risks to people and the review of these known risks.

We looked at how the service managed risks that may affect people in an emergency. We found that appropriate fire risk assessments were in place, fire safety equipment was serviced, there were plans for how each person was to be evacuated and staff knew what they needed to do and had been involved in fire drills. The provider had ensured that appropriate steps had been taken to keep people safe should there be a fire.

At our visit in April we became aware that there was some equipment that was not working including two people's ensuite bathing facilities and a ceiling hoist. Interim arrangements had been made to use the communal assisted bathing facility and a floor hoist. At our November 2015 visit we found occupational therapy assessments had been requested to find out what would be the most appropriate new bathing facilities to meet the needs of the two people. Funding had been set aside to refurbish both bathrooms but these had yet to be completed. The ceiling hoist had been replaced.

When we visited in April 2015 some staff told us there were not enough staff available when people needed them. We found that in the desire to ensure that individual people received support in emergency situations there had been a night when there was not adequate staff for the remaining people. During our visit we saw that an agency member of staff was not aware of the needs of people who were deaf / blind as it was their first time working in the home. Another member of staff was not available for work and the staff member in charge was trying arrange further cover whilst also trying to ensure that care provided met the needs of the people. This meant that half the staff on duty were agency staff. The person was not supported to participate in the activities that had been scheduled In June 2015 we saw that a relative had written that: 'Temporary staff need to be told that I visit so that they know who I am,' and a relative told us that they were concerned about the changes of staff and managers. We saw an entry in the complaints log which indicated that in October 2015 a family member shared that they were concerned about the number of agency staff working at the home.

In the inspection in November 2015 the manager advised that appropriate levels of staff had been provided during recent events and urgent situations. We were informed later that night time cover was not quite the same as had been described in that one of the two staff on duty at night was a sleeping - in member of staff bedroom available for staff. All of the staff we spoke with in November 2015 told us that they were able to provide support as people's care plans directed. They told us that staffing had improved and the manager was able to show us how the staffing levels were assessed to ensure that people received the care to meet their needs and as funded. Staff told us they had been informed about the recruitment of new permanent staff and a potential new manager taking over the service.

Good

Is the service safe?

At the time of the November inspection we saw that staff were available when people required support and available to provide time for interests and activities that people wanted to do.

We spoke with three staff members about how they were recruited. They told us that employment checks such as police checks and references had been carried out before they started to work at the home. We looked at three staff records which confirmed this. Some staff (bank staff) that worked at the home occasionally had information about their employment kept off site. This information was provided on our request and this confirmed that bank staff were also recruited appropriately.

Prior to our inspection in April 2015 concerns were raised that there had been an occasion where there had not been enough trained night staff to ensure that people received medicines from appropriately trained staff. We found that there were no other issues about how medicines were administered and stored.

In November 2015 we observed staff encouraging a person to take their medicine. The level of personal support provided matched the detailed plan of how to administer a person's medicines. We looked at the administration of two people's medicines including medicine records and found that people's medicines were stored safely and administered as the prescription stated. A small amount of 'when required' medicines were stored separately for people and for one person this had not been needed for over eight months and the medicine had been retained. These medicines should be returned as suggested by the available guidance. We saw evidence that the management checked medicines routinely. Staff were aware that they were unable to administer medicines until they had the proper training and their competency checked. Staff had been undertaken training in medicines and there had been additional guidance devised to cover if due to unforeseen circumstances a medicine trained member of staff was not available and the actions that needed to be taken by the on-call manager. The provider had taken appropriate steps to ensure medicine was appropriately managed.

Good

Is the service effective?

Our findings

In both April and November 2015 staff we spoke with told us that there was enough training. During our observations we found that staff assisted people appropriately and in the way determined by their care plan. When we spoke with them about people's health and care needs they were knowledgeable about them. Newer staff told us that had an induction when they started work at the home and that they had an opportunity to read about people's care needs and were introduced to the people living in the home. Staff told us that they had routine regular training to keep them up to date in topics such as first aid and health and safety. This was confirmed by the limited training records we were supplied with. Staff told us they training specifically to meet the needs of the people they were caring for. A member of staff told us: "I worked here as a bank member of staff… although I had training at the agency I had to do it all again with Sense to make sure I had been trained in enough depth." Another told us: "I was assigned a staff mentor on my first day and even now I find that they are very supportive." People were receiving care and support from staff that had appropriate training.

In April 2015 one staff member told us they had not been inducted into their role and staff told us their supervision was: "Hit and miss." In November 2015 staff told us that they had regular supervision to identify how they could best improve the care people received. They discussed any concerns about: any of the people living in the home, staff or their working conditions. This helped ensure that people were supported by staff who were aware of their current health needs.

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). The provider had made DoLS applications for all of the people living in the home as they did not have the capacity to decide to live in the home. These applications had been sent to the appropriate local supervisory body and two applications had progressed to an authorisation being granted at the time of the inspection. One we had been advised of in March 2015 and other we had not.

Staff told us they had received training in the MCA and DoLS. When we spoke with them they had an understanding about the legislation. Staff were aware they must ensure that people were consenting to care and treatment. A staff member told us: "If, for example [person's name] is indicating they do not want help with their personal care, I gently stroke their hands and feet until they are happy for me to continue." We observed situations where people were refusing meals and staff removed the meals and offered alternatives, these actions indicated to us that people were supported to make decisions where possible. At times, people living in the home needed support with health conditions where sedation was needed to treat. Although the manager was aware of the need to consider an emergency DoLS application for one person, an application had not been prepared as the appointment date had yet to come through and this could delay the process. Consideration should be given for a best interest process where people need as required medicines to support diagnostic tests. People were supported to go to places outside of the home almost daily so as minimise the effect of any deprivation of liberty.

We observed breakfast and lunch time meals. We saw that staff gave people appropriate support to eat and drink according to the recommendations from individual assessments to prevent choking or to manage specific health conditions. Where people were having difficulty consuming good amounts of food or drink we saw that professionals were contacted for advice and information was available to staff about changes in diet. We spoke with three staff about a change in a person's hydration plan and found that not all were aware of the changes. We found that menus were planned on a weekly basis with people to ensure they maintained a balanced, healthy diet. Arrangements were being made to vary these menus to ensure that individual people had food at the appropriate texture. People were supported to have food and drink in a safe way.

We saw records of planned menus for people but what and how much people ate was not recorded well. For example,

Good

Is the service effective?

we noted that nothing was recorded for a whole weekend for a person and days where a person had only one meal recorded, both records had been completed without insertion of any explanation. There was a lack of evidence to show that people had the opportunity to eat and enjoy foods that met their cultural needs on a regular basis. We checked the storage of food and found that outdated food had not been discarded from the fridge.

In April 2015 we saw a record that one person had not attended a recent emergency appointment with their GP because there had been no information recorded about why they needed to go.

In November 2015 we saw that where people needed support with their day to day health needs they received this support. For example we saw good communication between staff when a person's usual breakfast meal needed to be changed to ensure that they remained well. People's care records showed that routine appointments with differing health professionals such as dentists and GPs were arranged to support them with their individual health needs. Records we looked at showed that if a health concern was identified then an appointment was made with the person's GP to identify the cause as soon as possible. Where people had emergency health needs we found records were kept of their appointments or stay in hospital so a full picture of people's health and care was maintained.

Good

Is the service caring?

Our findings

On both of our visits staff were able to tell us how they communicated with the individual people who lived in the home. We saw that staff used the methods of communication described in each individual's care plan to good effect. We saw that staff continued to speak with people when using other preferred method of communication such as hand under hand communication, objects of reference or signing. This ensured that people could use any residual sensory ability. We saw that staff used the preferred communication methods to alert people to any danger or gain consent for intervention. We saw that they spoke to people with affection and kindness. Staff's communication with us about people was also kind and considerate.

People were supported to be as independent as much as it was safe to do so. We saw that people were encouraged to retain their abilities whether this was with retaining their mobility, ability to get in and out of a wheelchair or skills with cutlery and cups. We observed that people who had ability to either sign or had other methods of showing how they felt were encouraged to use these communication skills such pushing away food they did not want to eat. There were symbols on all the door ways for people to feel to identify their place in the buildings and further symbols at different levels where this was important for a person.

In April 2015 when we visited we found that information about people was displayed on the doors to their bedroom. Although this was a way of staff gathering useful information about people's likes dislikes and skills it was available to workmen who were in the building on the day of our inspection. This did not respect people's dignity and confidentiality. The manager ensured that the information was removed and in November 2015 when we visited such information was not on display in the corridors. Staff knew the people who lived in the home well and spoke about their health challenges in a sympathetic way. Staff were able to tell us how they helped preserve people's dignity when supporting people with their personal care. All of the people living in the home had individual bedrooms with ensuite assisted shower or bathing facilities which afforded them privacy.

In a comment book a visitor had made two positive comments about staff's attention to their relative's personal care and staff's attention to matching their relative's clothes and added: "Well done to staff." A relative told us that the care of their relative was alright but that she missed a member of staff who worked well her relative. In November 2015 we saw that people were dressed in individual styles that reflected their care needs, gender and culture and for one person their interests in a football team. We saw people were supported to have their personal hygiene such as hair care needs met. We found this reflected information available in their care plan.

Good

Is the service responsive?

Our findings

All of the people using the service had lived together amicably for a number of years, with no new admissions. Records showed that relatives and, health and social care professionals had been involved in bringing together people's care plans. Care plans we saw over both of our visits in April and November 2015 had changed but on each occasions we saw that they included people's personal history, individual preferences and interests. They reflected people's care and support needs. Staff we spoke with were aware of recent changes in people's care needs and were able to tell us mostly about how these were managed. We checked the care plans of two people that had recent changes in their care and found that care plans had been altered so that staff had detailed instructions to follow. This helped to ensure that people had consistent care.

We looked at the arrangements for supporting people to participate in the interests and hobbies they liked. We saw that people had some individual interests that staff supported and also that they attended larger organised activities arranged with Sense. In April 2015 we found that staffing issues had affected how many of these activities people attended and subsequently how many people were able to go on planned holidays. A person complimented the staff on taking their relative on holiday but another person who lived at the home had not been on holiday and the manager and a member of staff told us this was because of : "Staffing issues." In November 2015 staff were able to tell us what individual people had programmed for the day. All of the people attended either a massage or ramble session in the morning. In the afternoon people took part in individual interests in the home. We saw that these interests were ones individual people enjoyed as they were smiling, joining in and / or concentrating on them. The manager told us of their intention to provide even more individualised leisure interests and to extend the day by providing more interests in the evening. People were supported to have leisure pursuits.

Staff supported people to maintain relationships with people that mattered to them. Some people had regular contact with family members; others were being supported to maintain contact electronically. A newsletter had started to be produced to keep relatives in touch with events in the home. One relative had commented in a care review that they were happy that arrangements had been made so their relative could visit them and did not want the person moving on to another care home or different type of service. Another relative told us that everything was all right when they last visited.

People living in the home were unable to make complaints about the care they received, or recognise other forms of written or pictorial procedures. As a way of trying to ensure people were happy with their care there were review meetings held by staff for each person living in the home where all aspects of the individual's care was discussed.

The registered provider had a formal procedure for receiving and handling complaints and concerns. A copy of the complaints procedure was displayed in the home. We saw that relatives who visited were given the opportunity to comment on the service by writing in comment books kept in their relative's bedrooms and a book was kept where visitors to the home signed in which was available to visitors to record concerns complaints and compliments. Concerns had been raised about the number of agency staff in the home but we saw no evidence of how this was responded to. We saw that several positive comments had been made by relatives and other people from within the organisation since our visit in April 2015.

Requires improvement

Is the service well-led?

Our findings

People who used the service were unable to tell us what they thought about the management of the home. At the time of our inspection in April 2015 the registered manager was not at work and the area manager was managing the home. Staff told us: "Staff are not being guided as they should be and are not working as a team," "We need good reliable management that are prepared to stay, generally people being looked after but there is a lack of structure and management" and "It has been difficult some staff are stuck in their ways and not open to new ideas." We were notified that the registered manager had left the service in July 2015. They had yet to cancel their registration with the commission when we inspected in November 2015.

In November 2015 the area manager was continuing to manage the home. A new manager had been appointed and was due to start in January 2015. Staff we spoke with at our November 2015 visit were more positive about the management of the service saying that the management of the service had improved. However we also received information of concern and suggestions that staff had been restricted in what they could say to us indicating that although staff presented a cohesive, open and effective staff and management team this had yet to be achieved.

The provider had systems in place to listen to staff who have concerns about the care in the home. The provider had been proactive in respect of willingness to listen and we saw advertised and staff told us that the provider had dedicated whistle blowing telephone number where staff could speak about the home's management in confidence. However numerous concerns were shared directly with us alleging that investigations were undertaken by staff too close to the existing management of the service and we continued to receive a small but steady number of concerns from people. This flow of contact indicated that the perception of the people reporting concerns to us was that some of the internal investigations of issues which impacted on the well being of people were not fair or balanced.

Information was not always available to us when we inspected. For example at our visit November 2015 we asked how the views of relatives were collected. The manager told us that surveys had been sent but they had no returns. The service action plan suggested that there had been a survey returned in July 2015. We asked about applications for Deprivation of Liberty Safeguards (DoLS) we were told all applications had been made that only one had been authorised. We had not been sent a notification of this authorisation as required. However we had been notified of another DoLS in March 2015 which had been authorised but was not presented with this authorisation on request.

We found that monitoring systems for food safety were not good enough. Although the manager had mentioned in a staff meeting and the record of this meeting had been displayed this had not resulted in sufficient improvements. All of the people living in the home had special requirements with food and we found that there was a lack oversight in respect of food menus and weight records. For example one person's weight was recorded to have increased by seven kilograms in less than three weeks without any investigation.

In April 2015 we found that there had been problems with the reliability of the assisted bathing facilities for two people. We were told that the money had been identified to refurbish these bathrooms. These had not been completed on our return visit in November 2015 the provider's action plan indicated that these will be completed by December 2015.

We found that people's care records had changed and there had been an attempt to simplify records used on a day to day basis. We found that there was no consistent format to the organisation of these records. The records did not always signpost staff to more detailed instructions. Staff we spoke with knew what they needed to do, but as the service had significant number of staff changes and had recruited more this could be a potential risk.

The systems in place to assess, monitor and improve the quality of the service provided were not consistently applied and failed to identify some of the issues that were noted during the inspections. In some instances where action had been taken to address issues the action taken had not been comprehensive and this had resulted in only partial solutions that were either not sustainable or not in line with the requirements of the law. This lack of good governance was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where 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 17 HSCA (RA) Regulations 2014 Good governance The systems in place to assess, monitor and improve the quality of the service provided were not consistently applied and failed to identify some of the issues that were noted during the inspections. In some instances where action had been taken to address issues the action taken had not been comprehensive and this had resulted in only partial solutions that were either not sustainable or not in line with the requirements of the law. Regulation 17(1) and 17(2)(a)(b)(c).