MacIntyre Care

Crosby Close

Inspection report

1 & 2 Crosby Close
St Albans
Hertfordshire
AL4 0AT
Tel: 01727 833142
Website: macintyrecharity.org

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
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 inspection was carried out on the 7 and 11 December 2015 and was unannounced.

1 & 2 Crosby close provides nursing care and support for up to 12 people with physical and learning disabilities.The location consists of two houses side by side and 6 people reside in each House. There were five people living at 1 Crosby close and 6 people living at 2 Crosby close on the two days of our inspection.

People were not always kept safe, although there were risk assessments in place they were not always followed. Medicines were not managed safely. Permanent staff employed at the service had received appropriate training for their role, but the interim manager told us they did not know what training agency staff had completed and this may well have compromised people's safety. We saw that agency staff had a 'profile' which provided some information but not in relation to training they had undertaken. Staff told us they felt supported and had recently had one to one meetings with their line manager.

Summary of findings

There were systems in place to monitor the quality of the service and action plans developed to address any issues found. However, actions relating to the improvement of the safe administration of medicines had not been addressed at the time of our inspection.

There was not a registered manager in post. The registered manager had recently left the service and the provider was in the process of recruiting a new manager for the service. There was an interim manager who was overseeing the day to day management of the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

The Mental Capacity Act (2005) provides a legal framework for making particular decisions on behalf of people who may lack 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. Where 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)

We checked whether the service was working in line with the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that most people living at the service were able to make their own decisions and those who were unable had their capacity assessed. The manager and staff understood their roles in relation to DoLS. DoLS applications had been completed for people who received constant supervision and were awaiting an outcome.

People received care that met their needs and we observed staff knew them well. People were unable to contribute to planning their care, however in the case of some people, family and relatives had been involved.

People attended day centres and were supported with other activities both in the home and the community.

You can see what actions we have asked the provider to take in the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

Medicines were not managed safely.

Staffing levels were adequate but required monitoring.

People were not always kelp safe, and staff did not always follow the safeguarding process appropriately.

Requires improvement

Is the service effective?
The service was effective.

People were supported by permanent staff who had been suitably trained.

People had been assessed in relation to MCA and DoLS.

People were supported to eat and drink appropriate amounts to support their health and wellbeing.

People were supported to access health and social care professionals.

Good

Is the service caring?
The service was caring.

People were treated with dignity and respect.

People's family and relatives were involved in planning their care where appropriate.

Relationships with family and relatives were supported and encouraged.

Good

Is the service responsive?
The service was responsive.

People received care that met their needs in a way they preferred.

Care plans provided staff with guidance on how to meet people's needs.

Activities were provided and people also attended day centres, and were supported by family to do activities.

Complaints were responded to appropriately.

Good

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

The service did not have a registered manager.

There were systems in place to monitor the quality of the service. However they were not always effective.

Requires improvement

Summary of findings

People and staff were positive about the leadership.	

Crosby Close

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and 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 7 and 11 December 2015 and was carried out by one inspector. The Inspection was unannounced and had been brought forward in response to concerns received at the CQC. Before our inspection we reviewed information we held about the service including statutory notifications relating to the service. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with four relatives for four people who lived at the service as people were unable to communicate with us due to their complex needs, three members of care staff, two nurses, the interim manager and the area manager. We received feedback from health and social care professionals who visited the home. We viewed two people's support plans and looked at recruitment profiles for three members of staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to complex health needs. We looked at other records including quality monitoring information and audits, complaints and supervision records for care staff.

Requires improvement

Is the service safe?

Our findings

People were unable to tell us if they felt safe living at the service. Relatives of people who lived at 1 Crosby Close told us they did not feel their family members were always kept safe. Relatives of people who lived in 2 Crosby Close told us that told us their relatives were always kept safe and that they had no concerns at all.

Risk Assessments had not been completed in relation to visitors who had been employed privately as personal assistants to support a person at Crosby close. The interim manager at the home told us they were not aware if any checks had been undertaken to ensure these visitors were suitable to be around the people who lived at Crosby close. Likewise these people had not been 'inducted' to the service and therefore were unaware of emergency procedures for example in the event of a fire they would not be aware of the persons personal emergency evacuation plan. Management were also unable to confirm if these people had received training or if they and the person they were employed to support by a relative, were covered by the company's employee insurance and public liability insurance. This meant that people who lived at Crosby close were placed at risk.

Staff employed at the home had some understanding of abuse. This included how to recognise potential abuse and how to report any concerns both to their manager and to external organisations such as the CQC. We saw that staff had received training on how to protect people from the risk of abuse and there was information displayed around the home. However, we reviewed safeguarding records and found that safeguarding processes were not always concluded. For example, one safeguarding alert related to a 'missing' epilepsy charger therefore the pager had no charge and would not have alerted staff if the person was having a seizure. The nurse told us they had spoken to 'someone' in the community learning disability team and they were referring to the Local Authority safeguarding team. The nurse did not followed up and no outcome was recorded so we could not be assured that this incident had been properly investigated, concluded and any learning to reduce the risk of a reoccurrence. In another incident a medication error had occurred and was referred to Local Authority safeguarding team but again the process had not been completed and no conclusion or possible learning from the incident had been recorded.

This was a breach of Regulation 13 of the Health and Social Care Act (Regulation Activities) 2014 Regulations because the rrovider did not have robust procedures in place to make sure people are protected from potential harm and safeguarding concerns were not dealt with due scrutiny and oversight to ensure the safety of people who use the service.

People's medicines were not managed safely. We were assisted by two nurses when checking the medicines. We found concerns with the stock balances and recording of some medicines. Medicine that was not a controlled drug was being incorrectly stored in the controlled medicines cupboard. There were three people who were prescribed Buccal Midazolam at 1 Crosby close. We checked records for the three people's Buccal Midazolam and found that the stock balance did not tally with what was recorded and there was no explanation as to the discrepancies. The nurse who was assisting us proceeded to change the record saying, "Oh I know what happened." This was done without checking any information or discussing with other staff to check what they were recording was in fact correct. We referred these concerns to the manager immediately. We have also made a referral to the local safeguarding team for investigation.

A medicines audit was undertaken by a local pharmacy in July 2015 and they recorded concerns about the balance and stock of some medicines. However, no action had been taken in respect of the audit findings. An internal medicines audit had been completed on 27 October 2015 did not record any concerns in relation to any medicines at the service. It recorded, 'appropriate controls are in place including secure double-locked storage, CD register and double signing. CD cabinet, CD Register and medicine administration records (MAR) charts'.

There were additional concerns around the safe administration of medicines. For example, we saw records which detailed five medicine errors which all related to a particular member of staff. We asked the nurse who was assisting us what action had been taken to reduce the risks of these incidents reoccurring, they told us a medication error form had been completed on one occasion. However, there was no evidence that the person had been required to do additional training or that as a result of the repeated medicine errors that any competency checks had been undertaken. This meant that the errors had continued over

a period of time. The senior staff at the home accepted that this should have been addressed at the time and assured us action would be taken to reduce the risk of this happening in the future.

We found in individual medicine cabinets in people's bedrooms that medicines were without lids exposing them to contamination, some had syringes stuck in the top of the medicine bottle, a Ventolin inhaler had no lid covering the mouth piece again exposing it to potential contamination and five different types of medicines did not have the date it was opened recorded, to inform staff how long it had been in use. These incidents demonstrate that medicines were not consistently managed safely and people may not have received their medicines in accordance with prescriber's instructions.

This was a breach of regulation 12 of the Health and Social Care Act (Regulation Activities) 2014 Regulations because management of medicines was unsafe and inappropriate.

Recruitment was managed by the HR department at head office so we were unable to review recruitment files. The interim manager told us that they were sent a 'profile' of the applicant. They went on to say that checks such as references and criminal record checks were completed by HR. We saw that dates the checks had been completed were recorded on the profile and confirmed staff did not start work until they had received confirmation that all checks had been completed. We were unable to check application forms for example to confirm that gaps in employment had been explored as these too were kept at head office. We saw that people had had criminal record checks when their employment commenced and were required to sign an annual 'disclaimer' confirming there had been no changes to their criminal record status.

People were supported in a timely manner. However, we noted that staff were busy supporting people throughout the inspection and there was little time available for them to speak with us to obtain feedback, this was particularly the case on the second day in relation to the availability of nursing staff. The home was without a registered manager and the area manager told us they were in the process of trying to recruit a manager and some additional nurses. On the two days of our inspection there was a nurse on duty in both 1 and 2 Crosby close. However, staff and the interim manager told us that sometimes one nurse covered both houses. The interim manager and nurse we spoke with told us this was an area that was currently being reviewed as they said that if the nurse was assisting a person in one part of the home and there was an emergency in the other part they would be unable to respond in a timely way.

A relative told us that due to the complex needs of some of the people who lived at 1 Crosby close and the procedures they required they felt that nursing staff did not always have sufficient time to spend with people doing their clinical processes. We fed back this information to management who did not agree that this was the case and they told us they were piloting some additional staffing options in an attempt to resolve and alleviate some of the concerns raised by family members.

People were unable to verbalise in detail their views in relation to their safety at the service. However, we did receive feedback from four people's relatives. The feedback was varied with two families having concerns about their relative's safety and the other two families telling us they were confident their relatives were kept safe. For example, one family member told us they had concerns about the clinical practices of the nurses at the home and gave us some examples of why they were concerned. The examples related to clinical procedures carried out by nursing staff at the home and told us their relative had been admitted to hospital frequently since living at the home. However, we did not find any specific evidence to suggest that the hospital admissions had a direct link to any of the procedures carried out by nursing staff at the home. We discussed these concerns with the area manager and were satisfied that nursing staff were working within the scope of the policies of the home in relation to clinical procedures such as the policy around how to perfom a procedure to 'suction' people for example.

People had their individual risks assessed and managed. Staff were familiar with how to support people safely and this was communicated daily at handover meetings and discussed at team meetings. We saw that staff supported people in accordance with their risk assessments. For example, there were safety pads in place for a person who had epilepsy and was at risk of injury and another person had a risk assessment specifically around support with eating safely because they were at risk of choking. People who lived at Crosby Close had complex needs and required

Requires improvement

Is the service safe?

constant supervision to ensure their safety. For example, people who had epilepsy, and we observed staff to be mindful of peoples complex conditions and to observe people at all times to help ensure they were kept safe.

Accidents and incidents were recorded and kept under review by the manager to ensure any actions required to reduce a reoccurrence was completed. This information was also monitored by the area manager who reviewed the information to help identify themes or trends. We saw that equipment was in place to reduce the risk of injury. For example, one person had a special bed with raised sides to minimise the risk of the person falling off the bed. We saw the appropriate assessments and safety checks were in place.

Relatives raised concerns about infection control and in particular in relation to the cleaning of feed tubes and peoples wheelchairs. At the time of our inspection cleaning tasks were being completed by both day and night are staff, however there were no formal cleaning audits in place or schedules and this was an area that required attention. On both days of our inspection we found the home to be clean and well maintained.

Good

Is the service effective?

Our findings

The views of relatives for the two houses were very different. Relatives of people living at 2 Crosby Close were positive about the skills of staff, whereas relatives of people living at 1 Crosby close felt staff were not sufficiently skilled and knowlegable for the role. One Relative told us, "They did not think Nursing staff always worked effectively." An example of this was on an occasion recently when a person had to go into hospital as they had become unwell, they have no verbal communication and there were not enough staff on duty to enable a member of staff to accompany the person to hospital and to support them through the trauma of the process. However staff told us that they regularly visited people who were inpatients in Hospital.

Relatives of people who lived at 2 Crosby close told us the staff were marvellous and they had every confidence in their skills and abilities. They told us they felt that staff had received the appropriate training for their role.One relative said, "We have never had any concerns about the skills and abilities of staff." Another relative told us, "The staff regularly used the hoist to transfer [person] and I am confident the staff worked according to their health and safety requirements."

The manager told us that supervisions had not been completed consistently but they had recently commenced again. Staff told us that they were supported with training and recently had 1:1 supervision with their line manager. However, although nursing staff told us they had 'clinical supervision' with an external clinician they did not receive a copy of any notes or minutes from the meetings and could not demonstrate to us that the meetings were effective in supporting their clinical practice. We asked how they would know what was discussed two months ago, or any actions or development needs could be measured from just having a discussion and not having anything they could refer to review or indeed reflect on their practice. They told us the clinician made notes and they could request these. However, this had not happened previously which meant that although they had the discussions they were ineffective in supporting staff with good practice and regular clinical updates that they could use as reference documents. We saw that agency staff had a 'profile' which provided some information but not in relation to training they had undertaken.

Training records showed that staff had received training in areas such as safeguarding people from the risk of abuse, health and safety and food hygiene. Nurses had received specific training relative to the needs of the people they supported. For example, in the care of people with epilepsy, suctioning people, and Percutaneous Endoscopic Gastrostomy (PEG) feeding and administration of medicines via the PEG. The Nurse told us that there were compertency checks in place and we saw evidence of this.

People could not consent verbally however staff told us they could read peoples facial expressions and body language to establish if people were agreeable to what was being asked of them. Relatives were also involved in some decision making and had signed consents for various aspects of peoples care and support. Staff told us that just because people were unable to verbalise their choices, it did not mean people did not have capacity. One staff member told us, "We have got to know people's facial expressions now or the way they look at you." Family members of people who lived at Crosby Close told us they had been consulted about consent and had been involved in supporting the process to make sure that staff knew about likes and dislikes and were able to give people choices in a way they could relate to.

We checked whether the service was working in line with the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that appropriate assessments had been done and submitted and were awaiting responses from the local authority.

People were supported to maintain a healthy and balanced diet. We observed on both days of our inspection in both 1 and 2 Crosby Close that people were given a choice of home cooked meals that were both nutritious, looked appetising and were served hot. It was clear from observing staff that a lot of thought and effort had gone into the preparation of food at the home. People were supported with eating and drinking throughout the day. People were weighed and particular attention was paid if people had any special dietary requirements for example a person who was fed via the PEG. Staff also told us that where people were at risk of choking they had a specialist speech and language team (SALT) assessment to inform staff how to manage risks and ensure people were supported effectively.

Good

Is the service effective?

People were supported to make and attend health related and hospital appointments. If required health and social care professionals would visit people in the home. For example, dentists, opticians or other specialist who may be required from time to time. Relatives of a person who lived at Crosby close told us that the staff had supported their relation when they were admitted into hospital and that they also visited the person most days to offer support and the reassurance of a familiar face. We saw that people had a 'Purple' folder which went with them to any health related appointments and where all health records were kept so that staff had access to information relating to people's health and well-being.

Good

Is the service caring?

Our findings

People were unable to tell us their views on the staff or if they were well cared for at the home. Relatives gave mixed feedback. At 1 Crosby close they told us the staff were caring generally, they just felt like they did not always had adequate time to provide a quality service. Whilst the feedback from relatives of people who lived in 2 Crosby close were extremely complimentary of staff.

During the two days of our inspection we observed the staff to be kind and caring when supporting people. We saw people reacting positively to staff. In some cases it was a smile, or a look or a sign that staff were able to pick up on. One member of staff told us, "I have worked here for years, these people are the reason I come to work every day. I just think the world of them, all of them." One relative said, "I can't find the words to tell you how much we value what they do for [person], not only that, they keep us informed they are amazing." Another relative told us "We would never have managed without them I don't know how they do it."

Relatives told us that staff were caring. One relative told us, "I really can't tell you how fantastic they are. It's so homely here and always a friendly face. They have done so much for [person]. They are just so special, I think the world of all of them and feel so lucky that [person] moved in here." We saw staff were gentle when assisting people and spoke with them in a nice and respectful tone. Staff were really attentive to people, they were in and out checking with people at regular intervals. For examples when staff were in the kitchen preparing the eveing meal they were chatting and offering them options such as shall we go to your room, or do you want to watch the TV.

People were treated respectfully and staff were aware of their right to privacy even if people could not verbalise this. Staff were discreet when supporting people with personal care. We observed that where a person had been supported with a drink their top had become soiled the staff immediately wheeled the person to their bedroom and assisted them to change so they would be more comfortable and preserve their dignity?. Several people wore clothes protectors, and we saw that these were removed as soon as the person finished their meal or drink, ensuring their dignity was maintained.

Staff knew people very well and when speaking with us demonstrated they thought of people they supported as human beings and individuals. Staff were able to describe what was important to people including their likes and dislikes. We observed several nonverbal communications between staff and people who were living at service and found these to be special and personalised. For example, we saw a person being offered an item to hold by ?, A member of staff said, "Oh no [person] does not want that [person] wants this." They offered another item and the person was observed to smile positively. They told us, "I just know by their facial reaction." It was clear from observing staff that all communication was important and they really went the extra mile to facilitate communication with the people.

People's relatives were involved in planning and reviewing their care. Staff told us it was really crucial to have the input from family members as people were unable to verbally express preferences and choices. Care plans were personalised and had information about people's lives which informed staff about what was important in people's lives, and who was involved.

The manager and senior carer both demonstrated they knew how to support people as individuals. For example, they spoke about people all being very different and having different but equally complex needs and told us they wanted to support people to have the best quality of care they could provide.

Families were very involved in supporting their relatives and were also very supportive of the home and the ethos. We saw many visitors during our inspection and relatives told us they were welcomed to the home at all times.

Good

Is the service responsive?

Our findings

Relatives gave mixed feedback about how responsive the service was to peoples changing needs. Although, not everyone was able to verbalise their experiences we observed that staff responded to people's needs when required, and demonstrated they knew peoples routines very well. Because of peoples complex medical conditions, their condition often changed or deteriorated quite quickly and the manager and staff told us how they responded in this situations. For example, when a person had to be admitted to hospital staff accompanied the person to hospital and the staff visited almost every day to offer support and reassurance to the person. In the case of another person their relative told us that when they become unwell they need medical intervention immediately and an increase in the number of times a procedure was carried out, staff responded appropriately to these situations. The manager told us they tried to be as flexible as possible to ensure they could always respond to peoples changing needs.

People received care that was personalised and tailored to individual needs. People had very complex needs which required very detailed and specific care plans. Their care was planned with family support and involvement. Staff told us they involved other professionals so as to provide a holistic approach. For example, they worked with physiotherapists occupational therapists and speech and language therapists when required to ensure peoples changing needs continued to be met. This helped to ensure that people received support which was shaped to their individual needs.

People were supported to take part in a wide range of activities. For example, some of the recent activities people were supported to participate in was a firework display at the home in November, a group sensory session, bowling, Christmas shopping and individual pampering sessions including foot and hand massages. Some people had pre planned activities while others decided on the day and subject to the availability of staff some were provided spontaneously like going to see the Christmas lights or just out for a walk. This enabled people to do activities which were meaningful to them and that they enjoyed.

The provider had a complaints policy and procedure in place and we saw that complaints, compliments and comments were recorded, investigated and concluded, where possible to the satisfaction of the person making the complaint. Information about how to make a complaint was displayed in the office and in peoples support files. We saw that there had been a number of complaints which had been investigated and concluded and several that were still in progress that had not yet been concluded. The interim manager told us they saw that complaints was a way of improving things and had no problem with getting complaints. We saw that there had also been a number of positive comments and feedback received.

People were encouraged to share their views during meetings and families were able to feedback on behalf of their relatives.

There was a range of equipment at the service which people required to keep them safe and to assist with transfers, bathing, relaxing, and alarms to alert staff if people were having a seizure, and cushioned walling to protect people from injury.

Requires improvement

Is the service well-led?

Our findings

There was no registered manager at the service and they had been without a registered manager since October 2015. The area manager was supporting the service along with an interim manager. They told us that not having a permanent manager at the service had impacted on the day to day management of the home and standards had dropped during that time. The area manager told us that they were in the process of trying to recruit a manager for the service but had not shortlisted anyone at the time of our inspection and were extending the closing date to give them the best possible chance of recruiting a suitable candidate.

The relatives also raised concerns relating to the 'effectiveness' of some of the procedures and told us they were not confident in the ability of staff in the home.

The area manager and interim manager were open and honest and told us they knew certain things needed to be addressed and they were positive these would be addressed a timely and appropriate way. We had requested an action plan from the interim manger but this had not been received at the time of writing this report.

Feedback from relatives in relation to the leadership of the home was mixed and concerns were noted especially in relation to people who lived at 1 Crosby close. However, the feedback from relatives of people who lived at 2 Crosby close did not experience the same issues and generally no 2 Crosby close was running well.

Relatives were aware of the role of the interim manager and were supportive of the arrangements and stability they brought to the service. The interim manager was known to people, relatives and staff as they managed a supported living service close by also run by the provider.

Statutory notifications were recorded and staff told us they were sent to CQC. However, we had not always received them and this was being explored to identify why there was an issue with receiving the notifications. Notifications are required to be sent to CQC to inform us of important events that happened in the home. For example, medicine errors. For the time being we asked that all notifications are copied to the relevant inspector to ensure CQC is aware of events in a timely way.

The interim manager was working on an action plan. For example, care plans were being reviewed and updated along with risk assessments. Staff were starting to receive regular supervision and staff meetings were being arranged and put in place. Relatives and staff were confident the required improvements would be made with the support of a permanent manager but were supportive of the interim arrangements.

There were monthly management checks carried out, and where shortfalls were identified actions were put in place and kept under review until the desired outcome had been achieved. However, routine audits in the home usually carried out by the manager for example cleaning rotas, menus, care plans and medicine checks had not been completed in recent months. This was an area that the interim manager was reviewing and required improvement.

Staff told us that they felt supported by the interim manager and were positive about the future of the service. A senior carer had just been appointed to 1 Crosby Close and they were in the process of reviewing systems and processes with a view to strengthening them.