Affinity Trust

Tilehurst Lodge

Inspection report

142 Tilehurst Road
Reading
RG30 2LX
Tel: 0118 967 4675

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Ratings

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

Overall summary

The inspection took place on 15 October 2015. This was an unannounced inspection. A comprehensive review was carried out of the service in line with the Care Quality Commission's five key areas of enquiry.

Tilehurst Lodge is a residential service for up to six people with learning disabilities or autistic spectrum disorder. Currently the home has four people using the service. People lead an independent life, with some holding employment. People accessed the community independently as they needed in agreement with the home. Risk assessments were completed to ensure measures were put in place to reduce risk before people went out independently.

The registered manager was new in post commencing employment as the registered manager in July 2015, although he had been employed for 12 months prior to registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

People were kept safe by appropriate recruitment arrangements. Systems were in place to recruit staff who were suitable to work in the service and to protect people against the risk of abuse. Sufficient staff were employed, with relevant experience and training to ensure the needs of people were met. Medicines were appropriately managed and securely kept. Staff competence was checked prior to being able to administer medicines independently. Guidelines for as required medicines were in place, reducing the possibility of over medicating.

The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). This provides a legal framework of protection for vulnerable people who may become or are deprived of their liberty. Appropriate authorisation applications had been made where necessary.

A number of risks related to the environment were present within the service. Fire doors were being propped open with items of furniture preventing automatic closure in the event of a fire. Fire equipment was not checked frequently to ensure it was functioning appropriately. Where issues were highlighted in checks, action was not taken to rectify the problem. This was a particular concern where water temperatures were exceeding the maximum safe temperature.

Care plans and risk assessments were written with people. These were reviewed regularly, with changes made to reflect the needs of the person. People were encouraged to maintain independence. They were involved in choosing the home's décor and encouraged to become involved in running the home. However, the home was found to be dirty. Toilet rolls and hand washing handtowels could not be found in the communal cloak rooms and bathrooms. A significant pungent odour was present in these rooms, specifically on the first floor.

Annual quality assurance audits were completed by the parent organisation. However the registered manager did not complete audits of any documents within his service. This therefore meant that he was not aware of some of the shortcomings in the paperwork and concerns that may have been picked up, had he reviewed these.

People felt that communication with the service was good. Staff were appropriately supervised, received handover, and attended team meetings. This allowed information to be shared as required. People felt that staff worked in a caring manner, always preserving their dignity and respecting their individual choice.

We found that the service was in breach of Regulations 17, 15 and 12 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014. The provider did not maintain accurate records in order to meet the requirements of the fundamental standards. The provider did not ensure the premises were clean. The provider failed to mitigate any such risks that may practically be possible and had not ensured equipment was safe for use. You can see what actions we told the provider to take at the end of 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 always safe.

Fire doors were propped open preventing automatic closure and fire equipment was not checked in accordance with health and safety policy.

Water temperatures were recorded significantly higher than the maximum safe temperature. Nothing had been done with this information.

The premises were not clean and free from risk of contamination.

People were safeguarded from abuse. Staff knew how to report concerns.

A strong recruitment procedure was in place. People were kept safe with appropriate staffing ratios.

Medicines were stored and managed safely.

Inadequate

Is the service effective?
The service was effective.

Staff received regular supervision and appraisals. Team and house meetings were held frequently.

Staff training was up to date, with a system in place alerting the registered manager to training expiring 12 weeks in advance.

Good

Is the service caring?
The service was caring.

People's dignity and privacy was preserved.

Staff worked in caring and respectful way, involving people in making decisions related to their care and life. People's choice was respected at all times.

Good

Is the service responsive?
The service was responsive.

Care plans were written with people and reviewed appropriately to accommodate changing needs.

Risk assessments were routinely reviewed and assessed for accuracy.

A system was in place to manage complaints. People were confident to make a complaint if necessary.

Good

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

Requires improvement

Summary of findings

No effective processes were in place to monitor the accuracy of the care provided.

Audits were not completed by the registered manager to establish where concerns or improvements were required within the service.

The registered manager was managing two sites, although registered at one location only.

There was an open culture within the service.

Tilehurst Lodge

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.

The inspection also included following up on three breaches of regulations found at the July 2014 inspection. Whilst there has been a change in regulations these breaches remained.

- The provider did not ensure care was delivered in such a way as to ensure the welfare and safety of each service user. Regulation 9(1)(b)(ii).
- The provider did not analyse incidents that resulted in or had the potential to result in harm of a service user. Regulation 10(2)(c)(i).
- The provider did not take reasonable steps to prevent abuse before it occurred and did not respond appropriately to allegations of abuse. Regulation 11(1)(a)(b)

This inspection was completed by one inspector on 15 October 2015. Before undertaking the inspection, we sought feedback from the local authority commissioners. We referred to the previous inspection report, the action plans written by the provider in response to these, and notifications. The provider is required to forward any notifications of significant events related to the service, to the Care Quality Commission.

During the inspection we spoke with four members of staff, including the registered manager, one team leader and two support staff. We spoke with two people who reside at the service.

Records related to care were looked at for all four people who live at the location. This included, care plans, risk assessments, hospital passport, records related to other health care professionals involved in care and any other additional document relevant to the support provided. Records related to the management of the service, for example staff files, complaints, quality assurance audits, manager audits and team / house meetings were viewed. We looked at records of employment and recruitment for three of the regular staff employed at the service.

Inadequate

Is the service safe?

Our findings

People were not kept safe. Fire doors were found to be propped open with chairs and cabinets, preventing automatic closure in the event of a fire. Fire evacuation, emergency lighting, monthly health and safety checks, personalised emergency evacuation plans (PEEP) for each resident were viewed and appropriate. However, the fire detection and alarm systems check were being completed infrequently. These were meant to be completed weekly. This meant that if there was an error on the alarm system and a fire occurred, staff may not be alerted to this, due to poor checks being kept on the equipment. Cupboards containing chemicals were left unsecure. Whilst water temperature checks were taken and recorded appropriately, these were not acted upon when anomalies were noted. For example, the maximum water temperature recorded as acceptable was 44ºC, yet recordings as high as 68.2ºC were recorded in the spare bedrooms for wash basins within the month of September. Neither staff nor management had acted upon this information. The registered manager contacted the maintenance team to resolve this issue during the inspection.

Whilst regular maintenance checks were completed by the service, it was found that important information was not appropriately acted on to keep people safe.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured the premises were always safe, for people to use. The provider had not done all that was necessary to mitigate any such risks.

During the last inspection it was noted the service was very poorly maintained. The gardens were risky for people to use, as appropriate handrails were not fitted, or were not secure. Whilst some aesthetic alterations have been made to the location including securing the garden, it was found that the service remained very dirty. Dust had settled on carpets in communal areas, cobwebs had dust on them in windows, stair railings had millimetres of settled dust. The front of the service contained broken furnishings from the home. On the first floor, a hole hand been punched into the wall, causing the plaster to be pushed in, it was unclear when this had occurred, as no report had been completed. Communal toilets did not contain toilet paper, hand towels or soap, therefore increasing the risk of infection. The toilets on the first floor had a very strong pungent smell of urine when we raised this with the manager, staff commenced cleaning..

The service was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which specify the premises should be clean.

At the last inspection on 25 and 29 July 2014 we asked the provider to make improvements and take steps to ensure care was delivered in such a way as to ensure the welfare and safety of each person. There was no behavioural support plan in place to reduce the risk of injury to one of the people living at the service. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following that inspection the provider sent us a plan telling us what actions they would take to reach compliance with the essential standards. At this inspection we found the provider had taken the action they said they would take and they now met the requirements of the regulation.

Risk assessments (formerly referred to as behavioural support plans) for individual people who use the service had been completed. For example, risk assessments for accessing the community independently and going on holiday were found to be completed. Any changes to risk were appropriately updated and reviewed, and communicated to staff, to read and sign to illustrate they knew how to manage the associated risk.

At the last inspection on 25 and 29 July 2014 we asked the provider to make improvements and take reasonable steps to prevent abuse before it occurred and to respond appropriately to allegations of abuse. This was in breach of regulation 11of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following that inspection the provider sent us a plan telling us what actions they would take to reach compliance with the essential standards. At this inspection we found the provider had taken the action they said they would take and they now met the requirements of the regulation.

People who use the service reported they “feel safe”. Staff had a good understanding of safeguarding and knew the

Inadequate

Is the service safe?

various types of abuse and what signs to look for. They were able to explain the procedure they would use if they observed or were made aware of concerns about abuse. Training had been undertaken by all staff in safeguarding. This was refreshed regularly. The internal company policy on safeguarding and whistle blowing was read by staff and referred to the guidance of the local authority in reporting of safeguarding incidents.

People were being kept safe by comprehensive recruitment procedures. Staff were vetted to ensure they were suitable to work with people. References were obtained to check on staff conduct in previous employment and a Disclosure and Barring Service (DBS) check was completed. A DBS enables employers to verify an applicant has no criminal convictions at the time of employment that may make them unsuitable to work with vulnerable people. It was found that DBS applications and "Adult First" checks were made for all staff. The Adult First checks a special register to make sure that the applicant is not barred from working with vulnerable people.

At the time of the inspection one person was on holiday, accompanied by a member of staff. The remaining three people were independent, accessing the community and employment without assistance. Staff levels reflected the needs of the people. More staff were on shift at times when people returned to the home. Rotas for the last six weeks were reviewed. Sufficient staff were found to be on site. Where a shortfall was noticed, staff from within the company were used. No agency staff were used at the service, which ensured consistency of care and support was provided at all times.

People were receiving medicines from staff who were trained and competency checked three times, before being signed off to administer medicines independently. Medicines were stored safely in a locked cabinet, using a NOMAD system. This is when the medicine is prepacked by time and date to be administered, reducing the potential of error. As required medicines had appropriate guidelines in place to ensure staff only administered these in line with prescribed instructions. For example "when feet are swollen". Medicines were ordered and delivered by a local pharmacy. Any unused medicines were disposed of appropriately, being recorded and signed to illustrate returning to the pharmacy.

Good

Is the service effective?

Our findings

People were supported by a team of staff who had undertaken a comprehensive induction process. The company's mandatory training plus specialist training in areas such as dementia, epilepsy, challenging behaviour were undertaken by staff to assist them with their role. An IT system was used by the service which alerted the manager 12 weeks in advance of training requiring updating. This meant that staff's training was always maintained relevantly up to date, allowing effective practice to be followed when supporting people. All documents related to people's care had to be read by staff prior to commencing work with people. Any reviewed documents were placed in a folder for staff to sign off as read, prior to being transferred into their daily files. This process aimed to enable staff to be kept abreast of the changing needs of people, and how to support them effectively.

Staff felt that the training programme was effective as training was offered face to face, as opposed to through e-learning. This allowed staff to explore topics further, gaining additional information to help them with their role. People's right to make decisions was protected. Staff received training in the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the metal capacity to so for themselves. The Act requires that as far as possible people who make their own decisions 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.

The requirements of the Deprivation of Liberty Safeguards (DoLS) were being met. 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.

Initially blanket DoLS applications had been made for all people using the service. This was rectified, with applications being made where this was applicable to the relevant authorities.

People received effective support in accessing health care professionals. People could see their GP, dentist, and other health care professionals such as optometrist as and when required. Contact sheets indicated where advice was sought, and what needed to be implemented as per advice of professionals. It was found that the advice was not always adhered to. For example, in one care file it was reported that "staff to support with this" under brushing teeth. However daily records illustrated that staff either asked or told the person to clean their teeth. This therefore meant that ineffective care was being received by this person. The manager told us new daily recording documentation would be introduced that would specify the tasks that staff needed to complete with people.

Fresh fruit was available to people in the dining room. Open access to the kitchen was given to people, with pictures provided on cupboards containing teas, coffees, bread, biscuits for quick reference. People collectively chose what meals they wanted for the week in advance, discussing this in a team meeting. Staff cooked with people engaging them in learning new skills and further promoting their independence. If people didn't want to eat the food on the menu for the day, they were offered an alternative.

Staff received regular monthly supervision. This allowed areas of professional growth to be further explored. Appraisals took place annually and aimed to look at the achievements of staff in ensuring effective support was provided to people. Team meetings records illustrated that these took place every six to eight weeks. Staff were expected to attend one in three of these meetings, however they were required to sign the minutes to illustrate they had read them for missed meetings. These meetings allowed practice to be discussed, updates to be provided and general successful techniques used by staff to be shared in effectively working with people.

Good

Is the service caring?

Our findings

People reported, “staff are really caring. They look after us”. Staff were observed during the course of the inspection to be treating people and approaching them with care and kindness. For example, when one person returned from work, and was asked if he would speak with us as part of the inspection process, staff reassured the person, and remained seated with them at their request during the chat. Staff spoke gently, using touch as reassurance.

The care plans were written with the views of people using the service as the main focal point. People told us “I was involved, yeah”. People were asked to sign they were happy with the content of their care plans, and how they were being supported. It was evident that staff knew people well and responded to their needs appropriately. Documentation related to the care people received was reviewed and updated in accordance with people’s changing needs.

People’s right to confidentiality and choice was respected. Staff had an understanding of equality and diversity. The registered manager told us how two people within the service were in a relationship. Staff respected their decision and ensured they were given their privacy at all times. This was not explicitly explained in the care plan, as it was felt that this was not necessary. We were told that this was discussed in a team meeting where it was reinforced that both people needed to have their privacy maintained, and this needed to be treated with the upmost confidentiality.

Personal history, likes and dislikes were recorded within people’s files. This information was used to encourage people to engage in external activities, explore avenues of employment or study and become more independent. It was evident that this was a successful technique, as people left the service at their leisure, returning by the evening or the agreed time.

People’s records, including care files were stored within the office on a shelf. It was found that the door to the office when staff were not using it was not locked. This was raised with the registered manager and we were reassured that documents would either be moved to secure cabinets or the office door would be locked accordingly.

House meetings were meant to take place monthly, as per registered manager’s reporting. However records illustrated that these actually took place every two months. These nevertheless were led by the people to discuss things related to the home, and their support in general. The home had recently been redecorated. It was found that during one of the house meetings, colour schemes were selected and finalised by people, and put forth to the provider. These were implemented in all communal rooms, thus ensuring the choice of the people using the service was reflected in their environment.

Good

Is the service responsive?

Our findings

Prior to moving to the service people were assessed to ensure they could have their needs met. Upon moving and periodically after, the care and support package was reviewed with each person. These were updated to illustrate the changing care needs of the person, and reflect the level of support required. Risk assessments were written in accordance with any changing needs where a risk may be posed, or when engaging in a new activity. These were also reviewed regularly to ensure the care was responsive to people's needs.

People were encouraged and supported to maintain relationships with family and friends. They were offered the opportunity to invite family and friends back to their home, or meet them in the community. The flexibility with communal space enabled people to have personal time with their visitors in private, without impacting on others in the home.

People were aware of how to make a complaint. They told us that they would speak with staff or management if something was making them unhappy. Complaints were logged on the computer system whereby they were dealt with and delegated by the wider organisation. Complaints needed to ideally be resolved within 28 days, as per company policy. In some instances this was not achieved, however the complainant was notified and kept up to date with the process and the reason for the delay. The service adhered to the principles of the Duty of Candour (Regulation 20), ensuring transparency during investigation and keeping the complainant abreast of the process. By dealing with all complaints centrally, the provider aimed to distinguish trends, and minimise repetition of concerns.

Activities were individualised, with people taking the lead on what they did and when. As the majority of people using the service were highly independent they made decisions related to activities on the day. Staff were told, and consulted on the plan prior to engagement. People stated, "I do a lot of things here. I go out a lot. I'm hardly ever in". Activity plans were not used in general due to this. Neither staff nor people reported the need to have a visual activity plan in situ.

Staff were able to recognise when people became anxious, and sought reassurance. For example during the inspection one person became a little anxious at our presence. Staff explained why we were there and offered the person the opportunity to go to another room, or engage with us. The person stated they did not want to speak with us, but wanted to be able to say a "quick hello".

Requires improvement

Is the service well-led?

Our findings

At the last inspection on 25 and 29 July 2014 we asked the provider to make improvements and take action to analyse incidents that resulted in or had the potential to result in harm of a service. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following that inspection the provider sent us a plan telling us what actions they would take to reach compliance with the essential standards. We found that the provider had introduced an effective system to monitor trends in incidents so to develop measures to prevent similar incidents from occurring.

At this inspection we found the provider had completed quality assurance audits annually, whereby a manager from another service reviewed the documents, and service. Feedback was obtained from people living in the home, as well as commissioners, with this informing the report and developing an action plan. Tilehurst Lodge was currently being audited every 3 months, due to the concerns raised at the last inspection. The registered manager did not complete any internal audits of systems and paperwork, and as such was unaware the advice of a professional had not been followed over a significant period of time. This meant that whilst the provider was completing QA audits – by speaking to people, reviewing general documentation, the registered manager was not completing any comprehensive audits. There was no means for the manager to have a continual evaluation of the service, recognise risk and take appropriate action. For example, if an audit was completed cross referencing of advice from professionals to how this was being put into action would be identified. Due to the fact that the manager had no systems to monitor and audit how a person was being offered care and support in relation to the care plan, he was unable to pick up on a the person not receiving effective care.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The registered manager, although only registered with the Care Quality Commission since July 2015, had been working at the service as the manager for 12 months previously. At the time of the inspection we found the manager was not on site. We were advised that he was currently managing two different locations, the other which he was not registered for. The registered manager felt he did not have sufficient time to deal with the issues prevalent at his location as he was managing a site that he was not legally accountable for. There was a structure in place that identified roles and responsibilities. Staff were aware of who to speak with regarding any concerns.

Whilst there was an honest and open culture in the home, staff felt that the service was not well led, due to the absence of the registered manager, when at the other service. This impacted on staff morale, where one member of staff stated, “I’m not enjoying my role to be honest”. Another member of staff reported, “not always listened to by management…nothing gets done.”

The communication within the home was good. Handover and shift plans were used. These were discussed verbally and written up. A communication book was used to pass on supplementary information to staff. A diary was used to detail appointments, schedule meetings, highlight supervisions, and advise of booked training.

Evidence of working in partnership was found in care files, although the advice was not necessarily acted upon in all cases. The home had a comprehensive schedule of maintenance works to be completed. This was arranged and sourced from outside contractors by head office.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person was not doing all that was reasonably practical to mitigate risk. Regulation 12 (2)(b). The registered person did not ensure that fire equipment was safe to use. Regulation 12 (2)(e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The registered person did not ensure the premises were clean. Regulation 15 (1)(a). The registered person did ensure that the premises and equipment maintained a standard of hygiene appropriate for which they are being used. Regulation 15(2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not have systems or processes established and operated effectively to ensure compliance with the requirements in this Part. (The fundamental standards) Regulation 17(1). The registered person did not have a system that enabled the registered person to evaluate or improve their practice in respect of the processing of information. Regulation 17 (2)(f).