Orwell Housing Association Limited

Marram Green

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Marram Green is a very sheltered accommodation providing personal care to people living in their own flats, some of these people are living with dementia. When we inspected on 27 and 28 July 2017 there were 24 people using the service. This was an announced inspection. The provider was given 48 hours' notice because the location provides a domiciliary care service.

This was the first rating inspection under the service's new provider who registered with the Commission on the 10 August 2016.

There was no registered manager in post. The previous registered manager had resigned in September 2016. 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. Although the provider was / had been actively trying to recruit to the position, at the time of the inspection they had been unsuccessful in finding the right applicant. Management support was being provided by a registered manager from another of the provider's sheltered housing complex and visiting leadership.

People told us, although the provider was trying to recruit to the post that the service had been without a registered manager for some time. We found although cover arrangements were in place, it was not the same as having a permanent manager to drive continuous improvement.

People told us they were provided with safe care and trusted the support workers coming into their home. If they had any concerns they felt comfortable to raise the issue with senior staff, and had confidence that their concern would be acted on.

There were systems in place which provided guidance for support workers on how to safeguard the people who used the service from the potential risk of abuse and avoidable harm. Support workers understood the various types of abuse that vulnerable people were at risk of and knew who to report any concerns to. Where safeguarding issues had arisen the service had learnt from these and taken action to reduce of it happening again. They understood their roles and responsibilities in keeping people safe, including following risk assessments which identified how the risks to people were minimised.

There were sufficient numbers of support workers who were trained and supported to meet the needs of the people who used the service. Recruitment of staff was done safely and checks were undertaken on staff to ensure they were fit to care for the people using the service.

People and their relatives were complementary about the approachable and friendly staff. Staff had good relationships with people who used the service and their relatives. People were consulted on how they wanted to be supported. The interactions between staff and people were caring, respectful, supported

people's dignity and carried out in a respectful manner.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People received care which met their individual needs and were being consulted about the care they received and, where appropriate, relatives were involved in contributing to the care provided. Where required people were provided assistance with their dietary needs to support their health and welfare. Where support workers had identified concerns in people's wellbeing there were systems in place to contact health and social care professionals to make sure they received appropriate care and treatment.

Where people required assistance to take their medicines, they told us they received these safely and as prescribed. Further improvements were needed in the management of topical creams and promoting a person centred approach. We have made a recommendation to support the service to improve in this area.

Different forums were used which supported people in voicing their views and influencing decision making. This included their involvement in the recruitment of staff. A complaints procedure was in place to ensure people's concerns and complaints were listened to, addressed in a timely manner and used to improve the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Support workers understood how to recognise abuse or potential abuse and how to respond and report these concerns.

Safe recruitment practices were followed and there were enough staff to meet people's needs.

People were provided with their medicines when they needed them and in a safe manner.

Is the service effective?

Good

The service was effective.

Staff were supported through training and supervision to maintain and develop the skills they needed to perform their roles effectively.

Support workers were aware of the Mental Capacity Act 2005 (MCA) and how this impacted on the care they provided.

People were supported to maintain good health and had access to appropriate services which ensured they received on-going healthcare support.

Where required, people were supported to maintain a healthy and balanced diet.

Is the service caring?

Good

The service was caring.

People were treated with kindness and had developed positive relationships with their regular support workers.

The support people received ensured their privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

People received personalised care which was responsive to their needs and their views were listened to and acted on. People and their relatives praised the staff and the support they received.

People knew, how to raise any concerns they may have about their care and the service.

Is the service well-led?

Requires Improvement

The service was not consistently well-led

There had been no registered manager in post for 10 months. We found cover arrangements and quality assurance processes in place to assess, monitor and improve the quality of the service. However, this was beginning to impact on the continuous development of the service.

Marram Green

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection was carried out by one inspector over two days: 27 and 28 July 2017 and was announced. The provider was given 48 hours' notice of the inspection because the location provides a domiciliary care service and we needed to know that someone would be available.

Before our inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service: what the service does well and improvements they plan to make. We reviewed information we had received about the service such as improvement plans and notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We attended a 'meet and greet' session set up by the provider, which enabled us to meet 12 people using the service and hear their views. We visited one person who used the service who had not attended the meeting. We spoke with two relatives, a visitor and observed the interaction between people who used the service and the staff.

We looked at records in relation to five people's care. We spoke with the provider's Head of Service, a registered manager from another of the provider's service who was providing management support, and five members of staff including team leaders, support workers and administrator. We looked at records relating to the management of the service, staff recruitment and training, and systems for monitoring the quality of the service.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe with their support workers and in using the service. One relative told us, "I trust what they do." This reflected the findings in the provider's 2017 satisfaction survey, where people had said that the care service they receive helped them to feel safe.

Checks carried out by visiting leadership included testing staff's knowledge on keeping people safe and ensuring that they had received training to support them in doing this. Staff told us they had, and further discussion showed, that they were able to relate the training to practice. One support worker said it was about looking out for the welfare of, "Vulnerable people," and if they had concerns about the person's welfare, "Report it to a Team leader straight away." They provided examples of the different types of abuse that they would look out for. This included financial, emotional and physical abuse. Support workers were aware of the provider's whistle blowing policy, one told us, "I would use it most definitely [report]," if they had a concern that a person may be at risk of harm.

The new provider made a safeguarding referral in September 2016, after they found a large amount of pain relief medicines belonging to people had gone missing. The joint police and local safeguarding investigation identified serious shortfalls in the service's management of people's medicines. Records showed that the provider had taken immediate action to deal with the situation and reduce the risk of it happening again. This included instigating their disciplinary procedures and implementing a new medicines management policy, guidance and training for staff. A staff member told us that the, "Medication policy we now follow is much more stringent." They felt that the new procedures put in place offered both, "Protection for them [staff] and for the safety," of the people they supported with their medicines. This was because, "Every tablet is accounted for," as there was a, "Tight reign and audit trail in and out of the building and all [staff] have had the new Orwell medication training." It demonstrated how the provider had learnt from the incident, taken action and made appropriate improvements to ensure people received a safe service.

People told us that they received their medicines when needed, this also included where applicable topical applied creams and ointments to the person's skin. Where staff were unable to locate a person's 'topical medicines' record, used by staff to confirm that the cream / ointment has been applied as prescribed, senior staff took action during the inspection to ensure another one was put in place. Reassurances were also given by the leadership that they would check to ensure that no one else's had gone missing.

One person told us that care workers always provided them with their medicines on time, "Never misses." Another told us they always received their medicines as prescribed, "Give or take five minutes." Where a person had requested staff to support them to take their medicines, we saw they were stored securely in the person's home. They told us that the key to the container was kept with staff. Although they were quite happy with staff having responsibility for the key, and staff were following the provider's guidelines, consideration could have been given in using a person centred approach. For example making arrangements to store the key securely in the person's own home.

We recommended that the service uses a reputable source such as The National Institute for Health and

Care Excellence (NICE) guidelines in 'Managing medicines for adults receiving social care in the community' to support them in reviewing their procedures and supporting people to receive their medicines in a person centred way.

Records showed that staff's competency to administer medicines safety was checked before they were given the responsibility of assisting people. Staff told us the competency test included being observed from, "Start to finish," was to ensure that it was carried out in a safe manner, "Correct meds [medicines] given at the correct time."

People's care records included risk assessments which provided support workers with guidance on how the risks to people were minimised. We saw where required, they were tailored to people's individual health needs. This included where people were at risk of choking or falling. An analysis of any accidents / incidents were kept, including falls. This included information on action taken to minimise the risk after any accident or incident, whilst respecting the person's rights to maintain their independence. One person told us that they were at risk of falling. That when they had fallen and used the emergency call system staff had responded straight away, "Brilliant make you comfortable."

Risks to people whilst being supported by staff were assessed and action taken to reduce any potential risk. This included giving guidance to support workers to ensure prior to using any of the person's mobility aids to assist transfers, such as a hoist, to check there were no faults and they were fit for purpose. Where a person, linked to their memory problems was at risk, staff were given clear guidance on the support the person wanted to ensure their safety. This included checking their water taps and appliances were off, and 'ensure that my patio doors and the door to my flat are locked' following their night visit.

People confirmed that that support workers were usually on time for their planned visits and stayed for the agreed length of time. Records seen supported this. If delayed people told us it would be because of an emergency, which they would be notified about. One relative told us that there had been, "No missed calls, odd time might be late, normally because of an emergency."

An on-going recruitment campaign supported the service in filling vacancies and covering absences. Support workers told us since the new provider had taken over, it was, "Easier to cover, use relief staff from other schemes, or if needed agency." They told us how using these resources ensured that there was, "No pressure on staff working extra," unless they wanted to.

Recruitment was carried out safely. Checks were undertaken on staff suitability before they began working in the service. Checks included references, criminal records checks with the Disclosure and Baring Service (DBS), identification and employment history. A care worker told us that the service, "Wouldn't let me start," until all this paperwork was in place.

Good

Is the service effective?

Our findings

People told us that they received effective care and that the staff had the skills and knowledge to support their care needs. One person told us, "We have confidence in them." Another commented that, "All the staff are brilliant," at their job. One person told us how new support workers shadowed more experience staff as part of learning and to see how they, "Interact," and learn knowledge of people's individual preferences.

Records showed that the service had implemented the care certificate for new staff. This is a recognised set of standards that staff should be working to.

Staff told us that they had seen an increase in training since the new provider had taken over. A support worker told us they had, "Done lots of training including person centre care, professional boundaries," under the new provider. At the time of the inspection we observed staff attending Health and Safety training. Where a staff member had completed a dementia care coaching course, they provided examples of what they had learnt and how they put it into practice. This included using a "Fresh face approach," by seeing if another support worker was more successful in reducing the person's anxiety, or in encouraging them to do a task.

Senior management told us that when the provider took over the service, to make sure that all staff had received the required training, the provider had decided to, "Start from scratch." Therefore all staff, irrespective of their previous training and qualifications, were going through the Orwell Housing training programme. In taking this action it will ensure all support workers had the skills required by the provider.

Where support workers told us they had noticed the needs of people using the service had increased, senior management acknowledge this. The range of people's needs had been taken into account when looking at the training topics that needed to be undertaken. Records showed that mandatory training in key areas, including safeguarding, moving and handling, to ensure people's safety were being prioritised, action was also being taken to source training / more in-depth training, tailored to the needs of the people they were supporting. This included training in motor neurone disease, percutaneous endoscopic gastrostomy (PEG) feeds and dementia. In taking this action, we saw it supported the provider in the knowledge that staff had the skills to provide effective care.

There were systems in place to ensure people were supported by staff who received regular supervision with their line manager and yearly appraisals. A support worker spoke of the benefits of having these systems in place, as it enabled them to have one to one feedback in private about practice issues / concerns without being disturbed. They said, "Can talk to the manager if things not going right, talk around it," and find solutions.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (MCA) 2005. People's care records identified their capacity to make decisions and included their consent to the care they were provided with. Where people required assistance to make their own decisions the

records identified the support they needed in their best interests, including those responsible, where appropriate.

We spoke with staff who had received MCA training, and who were able to demonstrate that they understood the principles of the MCA. They were able to provide examples of how they supported people to make choices, and ensuring they gained people's consent prior to providing support. Staff said how they always checked with a person if they wanted to take their medicines. They had awareness of the role of advocacy, and how to contact them to support people in making important decisions about their health and welfare which they may require support in to ensure it was being made in their best interest.

Where required, systems were in place to support people to maintain a healthy diet and / or with the preparation of meals and drinks. This included supporting people to make 'good' food choices to support their individual health and welfare. Discussions with a person's relative and staff demonstrated how they had jointly worked with health professionals, including a diabetic nurse specialist to monitor and support a person to make better diet choices, which had a positive outcome in stabilising their blood sugar levels.

Following the closure of the public onsite cafeteria, the care workers had continued to use the facilities to enable people they were supporting with their meals, to eat together. They found that this supported people to make meal times a more social occasion, which they found encouraged people of low weight to eat more, and reduce the risk of social isolation.

People were supported to maintain good health and seek support from health professionals, were required, and if applicable their relatives kept informed of any outcome of professional's visits. Where applicable, people's care plans provided information on health and social care specialists involved in monitoring their health and welfare, and how to contact them if they had concerns. Records showed where this had happened, and the outcomes recorded to keep support workers updated to ensure a consistent approach to meeting people's needs.

Good

Is the service caring?

Our findings

People using the service told us that staff treated them with respect and kindness. One person told us, "They are all very nice…they are like a family." This reflected the comments from people using the service who we met during the, 'meet and greet' session organised by the provider, where people described staff as, "Lovely," "Very good, very helpful," and, "Very polite and kind." People spoke about individual members of staff, who they got on with well and had built up good relationships.

Staff spoke about people in a compassionate way, and the fulfilment they received from supporting people. One care worker said they found it, "Rewarding helping people… Knowing I helped someone made a difference." They provided individual examples where they, and other care workers tried to ensure wellbeing in people's lives. A relative provided an example of how staff supported a person to feel valued by facilitating them to run activities for others living in the service.

We heard staff involved in friendly banter with people, and engaging in meaningful conversations which showed staff had awareness of the people's lives and interests. It demonstrated the people felt comfortable with staff. One support worker told us how they observed for any signs of ill being when supporting people, "Know them so well; know when sad, if something wrong." They acknowledged that it would be the person's, "Choice if they want to discuss," why they felt that way, but would try and find out to see if they could help.

Discussion with people and their relatives demonstrated how staff were actively involving people in making decisions about their care and support. This included making information available to people in the housing complex on how to access external bodies, community organisations and advocacy service that could provide independent support and advice. We noted that a Citizen Advice Bureau was also located in the scheme, which could be easily accessed.

People also told us about their involvement in recruiting new support workers during their 'Open day' selection process. This showed that people's views were valued and listened to. A relative was very positive about the involvement of people in selecting who would be coming into their homes, providing their care. They said, "Better than interviews…It's a good way, these people [potential staff applicants] could be looking after [their relative] but have no compassion." However using this format, enabled people to share their views and, "See how they [applicants] interact." We found by using observation and feedback from people supported the management to identify those staff that had the intuitive values they were looking for in their staff. One person told us that the provider held a, "Meeting every month," which fell on the day of our inspection, and was well attended. With representatives from both the leaseholder / landlord side and care provider, it provided a forum where people could raise issues about the premises and how the 'wellbeing' element of their support was run, as well as any care issues.

The service promoted and respected people's privacy and independence. That staff were mindful that it was the person's home, and would only enter with the agreement of the person they were visiting. Or where applicable, follow the person's instructions for entering / leaving the person's flat. People told us they made

the decisions on how much support they required, and staff acted on what they said. One person said how staff encouraged them to retain their independence, by letting them, "Do as much as you can for yourself," but if they, "Get stuck they help you."

People's records identified the areas of their care that they could attend to independently and how this should be respected. They also provided 'Goals' which included how people maintained independence as long as possible, and how staff were to assist them to do this. For example one person asked staff to let them be independent in their personal care, 'As I am able, but need you [staff] to wash / dry the areas that I am unable to reach wash/dry effectively on my own upholding my dignity at all times'.

People told us support workers ensured that they did not feel embarrassed whilst being supported with their personal care by ensuring their privacy. For example, one person said that staff when supporting the person to use the toilet, would say that they will, "Comeback in a few minutes and leave you." Remaining within ear shot, if needed earlier.

People told us living in the complex enabled to retain their independence in their own home, retaining contact with their family and friends. Where people felt they were risk of social isolation, care workers supported them to meet others living in the complex and join in with activities.

Good

Is the service responsive?

Our findings

People told us that they received personalised care which was responsive to their needs and that their views were listened to and acted on. One person said that care workers were, "Very good," in responding to their needs. A relative told us how the support given had increased the person's independence and brought quality to their life.

Each person using the service had been consulted about their preferences and support needs. Care records provided a range of information about the person and their needs, which supported staff in providing person centred care. Areas covered included information on the person's, physical, medical, mental, emotional, nutritional, behavioural and safety needs. For example, where it was recorded that that 'dull weather' could have a negative impact on the person's' mood, there was guidance for staff on how they could use positive distraction techniques, known to improve the person's well-being. The guidance given further demonstrated the care worker's knowledge about the person and their likes and dislikes, which was supportive of person centred care.

One person showed us the copy of their care plan they kept in their home. This enabled both them, and staff to use as a point of reference, as it provided information on the person's needs, and guidance for staff on how the person wanted to be supported. We saw where people had signed and dated to confirm that they had been asked about the level of support they wanted, and agreed with the contents of their care plan. Another person said that they and their support worker had gone through their care plan like a, "Fine tooth comb," to ensure it reflected their preferences and level of support they required.

The support workers told us how they responded to people's changing needs. This was further reflected in the 'updates' recorded in people's care plans. It demonstrated what people and their relatives told us, that staff were responsive in keeping their care and support needs under review. We noted that this included where a person's mobility had deteriorated and showed that the guidance to staff had been updated to reflect this to ensure the person's safety and well-being.

People knew who to speak with if they needed to make a complaint. There were systems in place for recording, investigating and responding to complaints. Information was also made available in the complex and the information pack given to new people using the service. The Provider Information Return (PIR) showed that they had received one complaint in the last twelve months. Where a person told when they had raised any concerns about care issues, they had been listened to and appropriate action take to resolve them. Senior management said how they welcomed any complaints, as they used the information, and any shortfalls identified as part of learning, areas that could be improved upon as part of driving continuous improvement.

Requires Improvement

Is the service well-led?

Our findings

The service had been without a registered manager since September 2016. We found that this was starting to impact on having good oversight of the day to day running of the service and in driving continuous improvement. Discussions with senior manager showed that they had been actively trying to recruit to the post, but had been unable to find a suitable applicant. They said that they would be continuing with the process until they found the right applicant with the skills and knowledge of managing a domiciliary service.

The current organisational structure consisted of manager from one of the provider's other service on site one day a week, who were supported by team leaders, and support workers. An administrator, whose primary role was the sheltered housing side, but they could be called upon to support the care administration if needed. There was also on-going support from the Head of Service who visited regularly.

People spoke positively about the quality of the service they received, but they felt the service needed a permanent manager on site. People and their relatives were complimentary about the temporary management cover being provided; they were used to having a manager located on site who they could speak to face to face. One person commented that they, "Do miss not having a manager." Another said although they felt comfortable to raise any concerns with team leaders, however some issues they would, "Only tell a manager."

In the provider's 2017 satisfaction survey, a relative had written, "I do feel the that the lack of full time site manager is taking its toll, stretching staff beyond what is reasonable at times." This reflected concerns mentioned during our 'meet and greet' session. Where people raised concerns about the changes they had seen in support worker's work load, which they felt was stretching staff, resulting in prioritising care and going without their breaks. One person pointed out the visit list care workers brought with them, had showed the large amount of care visits they had to cover. This also reflected the feedback we received where staff said they had problems fitting in their breaks. This had often resulted in them taking shorter breaks, or going without.

We saw that the 'route list' provided to support workers was broken down in quarter hour slots. Although breaks had also been allocated, there was no monitoring to ensure this was happening. We also identified where effective risk assessments had not been put in place to support with staff's identified health conditions to support them in making any reasonable adjustments if required. When we fed back these concerns to senior management, they took action straight away to put the risk assessments in place. They also told us they would put systems in place for support worker's breaks to be monitored. This would enable them to identify where they were not having them, and take action to address it.

People spoke well of the staff, and discussions identified that the changes brought in by the provider had not impacted them receiving quality care. One person commented that, "Care wise," they had seen no change, and would definitely recommend the service to others. However they had, "Got the vibes things had not been done correctly and have been put right now," and was being addressed. One staff member told us that after the safeguarding incident relating to medicines management there was a, "Shake up," linked to

not all the required records being in place, or were needed to be more robust.

Discussions with management and staff identified how the more effective management of ensuring staff were supported to fulfil their role, staff development, and ensuring people received a safe, quality service. Feedback we received also identified how the changes had impacted on staff morale, which was variable depending on their role. For example, team leaders told us how they had taken on a more supervisory role, and given delegated responsibilities. One spoke about the, "Great support from Orwell staff."

Although the majority of feedback from staff showed that staff morale had been variable during the last few months, as one support worker commented, "So much gone on, so much changes, we have clubbed together," to see it through. The more in-depth quality assurance systems put in place following the safeguarding in September 2016, had identified shortfalls which had needed to be addressed. This included medicines management, training and care records. These shortfalls, when raised with staff, a support worker told us it had the impact of them feeling demoralised. To support staff, and where required re-instil confidence in their abilities, an experienced staff member from one of provider's other sheltered housing complex was working in the service, to provide support for three months as a team leader. This enabled them to share their experience and expectations of the role.

Staff felt that communication could be better. One support worker felt at times they were, "Meant to be mind readers." The results of the provider's 2017 'Employee Survey' where employees had felt that management were not always sharing 'enough of the important stuff with you and do lots of telling but do not listen enough'. To address this as a provider, they were taking action to address this, including asking staff during team meetings how they could improve in this area, and the use of targeted work place surveys to explore this further.

We found during discussions with people, their relatives and staff, more effective communication was needed relating to the role of the domiciliary service, what was provided, and what comes under the 'well-being' element which was not regulated by the Care Quality Commission. For example, where a support worker felt to ensure people's safety there should be another support worker employed in the evening to provide support if needed. This lacked awareness around the difference between a residential care service, and a domiciliary service where staff were employed to visit people at set times. The previous lack of understanding about the difference between services had been addressed by the provider which had an impact, including a reduction in what people saw as staff having the time to sit socialise / organise activities, which was not required as a domiciliary service and these needed to be financed from the appropriate budget / or care package.

People spoke about care visits that were being interrupted by the support worker's mobile telephones' ringing. When we explored this further with senior management, we identified that some of the calls were linked to the need for staff to respond to the external doors, to enable people to enter the public areas. Action needed to be taken to resolve the situation as it impacted on the quality of service people were receiving.

There were quality monitoring systems in place to ensure people were receiving quality care, and to address any shortfalls. This included regular audits and checks of high risk areas, such as medicines, incidents, falls, nutrition and review of people's care plans. Where shortfalls were identified actions were taken to address them as part of learning from, and driving continuous improvements to ensure people experienced a quality, safe service.