Striving for Independence Homes LLP

Honister Gardens Care Home

Inspection report

6 Honister Gardens, Stanmore, Middlesex, HA7 2EH
Tel:02089070709
Website:www.SFIcarehome.co.uk

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Ratings

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

Overall summary

This inspection took place on 6 February 2015 and was unannounced. At our last inspection in December 2013 the service had met all the regulations we looked at.

Honister Garden provides accommodation and personal care for a maximum of five people with learning disabilities. At the time of this inspection there were four people using the service.

The service had a registered manager. 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 and associated Regulations about how the service is run.

There was no effective system in place to make sure that the registered manager and staff learn from events such as accidents and incidents, complaints, concerns, whistleblowing and investigations. This increases the risk of harm to people and fails to ensure that lessons are learned from mistakes. We have given a recommendation about this.

There was a lack of a consistent and thorough supervision and appraisal system for staff at the service. This meant that people were not cared for by staff who received effective support and guidance to enable them to meet their assessed needs.

People's health needs were identified and they had access to relevant health professionals when needed.

Summary of findings

However, some aspects of medicines management were not safe. People on medicines prescribed to be used 'as required' or PRN did not have protocols to support staff in their use. This meant that people on PRN may not have received their medicines when they needed them.

The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. We observed that people were happy with the care provided by the staff. Interactions between staff and people were caring and respectful. Staff had relevant knowledge regarding people's routines, and their likes and dislikes.

People's health and care needs were assessed with them, but they were not always involved in writing their care plans.

The provider did not have an effective quality assurance system. The system did not systematically ensure that staff were able to provide feedback to their managers, which meant their knowledge and experience was not being properly taken into account.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

The registered person had not protected people against the risks associated with unsafe use and management of medicines. This was in breach of regulation 13 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.

The registered person did not have suitable arrangements in place to ensure staff were appropriately supported to enable them to deliver care to people safely and to an appropriate standard. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also found the registered person had not protected people against the risks of inappropriate or unsafe care by means of the effective operation of systems to assess and monitor the quality of services provided. . 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.

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. People prescribed medicines to be used 'as required' or PRN did not have protocols to support staff in their use.

Safeguarding procedures were robust and staff understood their role in safeguarding the people they supported.

There was no effective system in place to make sure that manager and staff learn from events such as accidents and incidents, complaints, concerns, whistleblowing and investigations. This increases the risk of harm to people and fails to ensure that lessons are learned from mistakes.

Requires Improvement

Is the service effective?

The service was not always effective. Staff had not received sufficient support to meet people's needs safely. Consistent supervision and appraisal processes were not in place.

Staff supported people to maintain good health and enabled them to access health care services as needed.

Staff provided appropriate support to ensure people had sufficient food and drink to maintain their health and wellbeing.

Requires Improvement

Is the service caring?

The service was caring. People were supported by kind and attentive staff. We saw that care workers showed patience and gave encouragement when supporting people.

People's preferences, interests, aspirations and diverse needs were recorded. Therefore care and support provided was in accordance with people's wishes.

Good

Is the service responsive?

The service was not always responsive. People's care was not always planned in response to their needs, such as for preventing falls.

The service held regular meetings with people who used the service in order to get their views on the service provided. However, these meetings were not always recorded and when they were recorded, we did no see evidence that they fed into people's care plans. This meant there was not always a clear record of people's views and agreed actions.

A range of activities were offered which people enjoyed.

Requires Improvement

Summary of findings

Is the service well-led?

The service was not well-led. The provider did not have an effective system of reviewing and analysing incidents and accidents. When accidents and incidents were reviewed the provider did not always take action to reduce the risk.

The systems for seeking the views of relevant persons about the running of the service and for monitoring quality and safety at the service were not robust or effective.

We found that systems to seek the views and opinions of relatives, people living at the home and key stakeholders required development.

Requires Improvement

Honister Gardens Care Home

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 checked 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 was carried out by one inspector. During the inspection we spoke with four staff members and two senior staff of the company, the registered manager and a professional involved in people's care. We were not able to speak with people using the service because they had complex needs and were not able to verbally share their experiences of using the service with us. We gathered evidence of people's experiences of the service by reviewing their care records, observing care and talking to their relatives. We looked at three care records of people receiving care and four staff records which included recruitment information.

Some people had complex needs so we used the Short Observational Framework for Inspection (SOFI) to observe the way they were cared for and supported. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

People who lived in the home were not safe because some aspects of medicines management were not robust. The provider did not have systems for auditing medicines and did not have protocols for people on medicines prescribed to be used 'as required' (PRN).

We checked the systems for the storage, disposal and administration of medicines in the home. People on PRN did not have protocols to support staff in their use. For example, a person on PRN of lorazepam did not have a protocol. It was not clear whether the medicines were given as prescribed. This meant that this person may not have received their medicines when they needed them.

There were no systems in place for regularly auditing the safe management of medicines at the home by the pharmacist or a qualified person from the management team. This meant that there were inadequate systems in place for the safe management of medicines at the home, placing people at risk associated with the unsafe use and management of medicines.

This was a breach of Regulation 13 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.

The staff personnel records we looked at contained a pre-employment checklist. Each file contained two references from previous employers, criminal records checks, proof of identity and address, along with documents confirming the right of staff to work in the United Kingdom. The registered manager told us that no one would be allowed to commence work until all the relevant pre-employment checks had been completed. This ensured that staff employed by the service were safe to work with the people they cared for.

The director of the service told us staffing levels and staff skill mix was informed by people's dependency levels. On the day of this inspection, the care home had four people, including one person who received one to one staff support. The registered manager told us the other three people's needs were less and were allocated one staff. There were two staff on duty.

Risk assessments were in place about behaviours which challenged the service. We observed one person who exhibited behaviours that challenged the service during the course of our inspection. Staff responded in a safe and sensitive manner which was in line with the guidance provided within the risk assessment for this person.

The service had a safeguarding adult's procedure in place. Staff knew how to recognise signs of potential abuse and the relevant reporting procedures. They were also aware of the home's whistleblowing policy and who they could contact to raise whistleblowing concerns. Staff had attended training on safeguarding adults so that their knowledge was up to date. The service had raised an appropriate safeguarding alert with the local authority since our last inspection and worked in cooperation with the local authority regarding safeguarding investigations.

There were systems in place to deal with emergencies. The provider had carried out a Fire Safety Risk assessment to ensure the premises conformed to fire safety standards. Staff told us they had received training and knew what to do in case of a fire emergency. They were able to describe what to do in each situation. The provider held regular fire drills.

The premises were well maintained and clean throughout during the inspection. We saw from the maintenance log that any areas identified in need of repair or maintenance were actioned. Regular checks were carried out on people's rooms and the communal areas for any maintenance issues. These reduced possible risks to people from the environment and equipment at the service. The registered manager told us equipment such as Zimmer frames and wheelchairs had been regularly checked. However, there was no official record of this.

Requires Improvement

Is the service effective?

Our findings

We observed people were looked after by staff who were kind and caring. However we saw that although the staff tried to provide the support people needed, they did not receive the level of support they required to effectively meet people's needs.

Staff files included information in relation to their induction, training and supervision. We reviewed four staff personnel records and saw that none of the staff had received regular supervision and appraisals for the past 12 months. Staff were unable to confirm that they received regular supervision with their manager. We did not find a consistent record of the supervision they had received. The registered manager confirmed that staff supervision had not always occurred due to many changes within the organisation, including the sudden departure of a senior manager from one of the provider's other services. Therefore, staff were not adequately supported by the management team to carry out their roles effectively. The staff files we checked did not show how their competence to carry out their duties was checked following the completion of the induction.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff training records showed staff had received up to date training in key aspects of their role such as managing challenging behaviour, moving and handling, health and safety, infection prevention and control and safeguarding.

Staff understood the requirements of the Mental Capacity Act 2005 (MCA) Code of Practice. MCA is legislation to protect people who are unable to make decisions for themselves. Staff had received MCA training and were aware of people's rights to make decisions about their lives. They knew if people were unable to make decisions for themselves that a 'best interests' decision would need to be made for them.

The registered manager and staff were knowledgeable regarding Deprivation of Liberty Safeguards (DoLS). The DoLS safeguards are there to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. Services should only deprive someone of their liberty when it is in the best interests of the person and there is no other way to look after them, and it should be done in a safe and correct way. At this inspection we saw that the provider had applied for DoLS authorisation for someone who used the service and was waiting for feedback from the local authority.

The support records of people receiving care showed that each person was regularly supported to see the health and medical professionals they needed. We saw records of referrals to GPs, screening tests, speech and language therapy, dietician, among other professionals who were involved. Two people had Health Action Plans (HAP). The HAPs detailed the actions that were required by each person receiving support, to maintain and improve their health and any help that might be needed to accomplish this. The other two people had been referred to a local learning disability team for an HAP assessment.

People were supported to eat appropriate food and drink that met their needs. Their support plans included an assessment of their nutrition and hydration needs. Where needed, guidelines had been developed by speech and language therapist (SALT) and a dietician. We noted this in cases where people had eating or swallowing difficulties. Relevant guidelines were made available by SALT for staff to support people with eating.

Good

Is the service caring?

Our findings

Interactions between staff and people were caring and respectful. People could walk freely and without hindrance. Staff had relevant knowledge regarding people's routines, and their likes and dislikes. Care plans were personalised around the needs of individuals. They included people's likes and dislikes and information about their previous life histories. This helped staff to better understand the people they worked with.

People's dignity and privacy was respected. Staff told us they supported people to manage as much of their own care as possible to promote their independence. Staff said they promoted people's privacy by making sure curtains and windows were closed when providing personal care. We observed staff respecting people's privacy by knocking on people's bedroom doors before entering and by asking about any care needs in quiet manner and without being overheard by anyone else. We noted that each person had their own bedroom which afforded them privacy. When support was required, people were attended to in a timely manner and staff were aware of people's needs.

Care records included details about people's ethnicity, preferred faith and culture. People were provided with cultural foods of their choice and supported to follow their chosen faith. Staff knew the importance of respecting people's diverse needs and choices. They gave us examples of how they respected peoples' diverse needs, including how they supported one person to go to church.

We observed staff interacting with people in a sensitive and caring manner during our inspection. We saw staff made the time to talk with people and explained things to them. We observed staff were calm and confident in carrying out their roles. They noticed if someone was distressed and gave reassurance and comfort. For example, we saw examples of staff talking in low tones to reassure a person who occasionally got unsettled because of our presents. Staff explained to us the person did not like visitors.

We noted people were involved in decisions about any moves between services and their preferences and choices were respected. In one example, the provider involved an IMCA (Independent Mental Capacity Advocate) to support one person to make a decision about their accommodation. The role of the IMCA is to support people who lack capacity, and represent their views to those who are working out their best interests. The preference of this person was respected.

Requires Improvement

Is the service responsive?

Our findings

We found that people's care was not always planned in response to their needs. For example, when we looked at records we saw that a person had two falls in January 2015, but their care plan did not specify how the individual wanted to be supported. Such as, when they wanted to get up in order to guide staff about the level of care they required. This meant that care in relation to preventing this person from falling had not been clearly planned and recorded so the person received care in a consistent way. This placed this person at risk of not receiving the care and support they needed.

Care plans reflected how people were supported to receive care and treatment in accordance with their needs and preferences. The personal files included a detailed account of all aspects of their care, including their personal and medical history, their likes and dislikes, their recent care and treatment. However, we noted details of family involvement had not been documented and updated in people's care plans. The care plans we saw were not signed by the people using the service and there was no information recorded as to whether they had been involved with their development.

The service held regular meetings with people who used the service in order to get their views on the service provided. However, these meetings were not always recorded and when they were recorded, we did no see evidence that they fed into people's care plans. This meant there was not always a clear record of people's views and agreed actions. At this inspection we observed that there was work in progress to transfer people's personal information and updated care plans to an electronic system, in order to improve the management of care records.

Care plans were centred on individual care needs and staff provided care and assistance accordingly. For example, one person who exhibited behaviours that challenged the service was referred to healthcare specialists. This resulted in the assessment of this person's behaviour through ABC monitoring. An ABC chart is an observational tool that allows staff to record information about a particular behaviour in order to understand what the behaviour is communicating. The provider developed a behavioural management plan, which helped to reduce the occurrences of behaviours, which challenged the service. This was confirmed by a professional we spoke with. They told us the provider had made some progress in the management of this person's behaviour.

The registered manager told us there were some activities on offer such as a bus ride on a Wednesday, when people were supported to go to restaurants and parks. There was no displayed information for people about the available activities. We found that people were not provided with meaningful and stimulating activities to meet their needs and reduce the risk of social isolation.

The service user guide contained the complaints procedure. The registered manager told us staff explained to people how to make a complaint. We were informed that the service had not received any complaints.

People were supported to meet their religious and cultural needs and several people were supported to attend church. One person was supported to go to church by staff.

We recommend that an up to date guidance is always made available for staff regarding how to support people when their needs change or when there is an identified risk.

Requires Improvement

Is the service well-led?

Our findings

There were systems in place for seeking the views of relevant persons about the running of the service and for monitoring quality and safety at the service. However, these were not robust or effective. The registered manager told us the service carried out an annual survey of people to seek their views about the service. However, we did not see completed surveys, analysis of results or action plan produced as how to respond to the survey. In addition, the service did not issue surveys to other relevant stakeholders such as relatives, staff and health and social care professionals. This meant the service was not able to learn and develop from the views of stakeholders or provide a service more responsive to the needs of the individuals. We found that systems to seek the views and opinions of relatives, people living at the home and key stakeholders required development.

The provider's systems to assess the quality of service were not effective as they did not always identify areas for development and improvement. The registered manager told us they carried out spot checks and audits on various areas of service delivery. However, there were no records of this to show what was being checked or how they assessed the quality of care of people received. Neither the registered manager nor a senior support staff were able to identify an improvement that had been made to the service as a result of its quality assurance and monitoring process. There was no action plan in place that would highlight any strengths and weaknesses in the service as well as any planned improvements.

People's care records evidenced a record of monthly meetings with their key workers. The registered manager told us meeting with people using the service were held so that people could discuss issues that were important to them. However, these meeting did not result in any action plan; they did not feed into the care plan and therefore nothing changed as a result of these meetings.

The provider did not have an effective system of reviewing and analysing incidents and accidents. When accidents and incidents were reviewed the provider did not always take action to reduce the risk. Accidents and incidents were not analysed for possible trends over time in order to reduce risk of re-occurrence. There was no system in place that analysed the outcomes of incidents and accidents in order to learn from these and to improve the quality of the service. For example, a person had two falls in the same month and both incidents occurred whilst getting out of bed, but no analysis of these incidents was conducted to inform risk reduction action.

There were limited systems in place for staff to discuss issues and influence the operation of the home. The registered manager told us staff meetings were undertaken regularly but we did not see evidence of this. Staff files identified formal supervision and appraisal did not take place regularly. This meant there were no systems in place to monitor staff development and make sure that staff were able to meet people's needs safely.

All the issues above meant there was a lack of systems in place to check that people's needs were being met and that the service was operating effectively. The provider had also not identified the shortfalls we found during this inspection.

This was a breach of Regulation 10 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.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered person must protect service users, and others, against the risk of inappropriate or unsafe care by means of the effective operation of systems designed to regularly assess and monitor the quality of the service and identify, assess and manage risks relating to the health, welfare and safety of service users and others, and, where necessary make changes to the treatment and care provided in order to reflect information relating to the analysis of incidents that resulted in, or had the potential to result in, harm to a service user. Regulation 10 (1) (a)(b)(2)(c)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person did not protect service users against the risks associated with the unsafe use and management of medicines by means of making appropriate arrangements for the recording, safe keeping and safe administration of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements to ensure that persons employed were appropriately supported by receiving appropriate training, professional development, supervision or appraisal.