

Partnerships in Care 1 Limited

Yew Tree Lodge

Inspection report

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19 February 2019

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Ratings

Overall rating for this service	Requires Improvement ●
Is the service safe?	Requires Improvement ●
Is the service well-led?	Requires Improvement ●

Summary of findings

Overall summary

About the service:

Yew Tree Lodge is a residential care home that can provide the regulated activity of personal care to a maximum of 16 people. Three of the beds are crisis beds, with the remaining 13 residential (long term stay). The service provides care to people who have a diagnosis of mental health issues. Many of the individuals having experienced periods of stay in hospital and require a level of support prior to transitioning to community based living.

People's experience of using this service:

- Risks were identified for people on long term stay and actions put in place to prevent these. However, no guidance was provided to staff on what action to take, if the risk occurred.
- People on crisis beds did not have sufficient risk assessments in place to detail how staff were to support them and keep them safe, on admission.
- By day two of the inspection the registered manager had mitigated all risks, and ensured all paperwork was up to date and relevant to people.
- People reported feeling safe and well supported by the staff team.
- Medicines were managed safely, by competent staff.
- Recruitment procedures ensured appropriate staff were employed to work with people and keep them safe, as much as possible.
- The service ensured that measures were in place to prevent the spread of infection. The home was clean and tidy. People reported no concerns in relation to cleanliness.
- People reported that staff and the management team were approachable. We were told they listened to concerns.
- Quality assurance surveys illustrated the service had sought feedback from people, relatives and health professionals, and had made changes, where possible.

Rating at last inspection:

The service was last inspected in February 2018 and was rated Good in all domains. The service did not have anyone using the crisis beds at the last inspection. At this inspection we found that the service required improvements specifically in supporting people in crisis beds. As a result, the overall rating has been amended to reflect this.

Why we inspected:

This was a focused inspection that was prompted by a serious incident that resulted in a person's death. As the death is currently being investigated, we did not look at this specifically during the inspection. We focused on the domains of safe and well-led for this inspection.

Follow up:

We will continue to monitor all information we receive about this service. This will inform our ongoing assessment of their risk profile and ensures we are able to schedule the next inspection in accordance.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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

Details are in our Safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led

Details are in our Well-Led findings below.

Requires Improvement ●

Yew Tree Lodge

Detailed findings

Background to this inspection

The inspection:

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, 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 prompted in part by notification of an incident following which a person using the service died. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risks, including documented assessments specifically focused around self-harm or suicidal tendencies. This inspection examined these risks.

The inspection was completed over two days. Day one was 29 January 2019 and the second was 19 February 2019.

Inspection team:

One inspector carried out this inspection.

Service and service type:

Yew Tree Lodge is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during the inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

What we did before the inspection:

- We looked at all the information we had collected about the service. This included previous inspection

reports, information related specifically to the concern leading to the focused inspection and notifications the service had sent us. A notification is information about important events which the service is required to tell us about by law.

- We contacted three professionals from the local authority, including the safeguarding team, and received feedback from all.

What we did during the inspection:

- We looked at five people's care plans, risk assessments, initial assessments, medication records and daily notes.
- We spoke with two people who receive a service. We spoke with six staff employed by the service.
- We looked at governance audits, including medication, care documents, health and safety and infection control.
- We also looked at records, accidents, incidents, the training matrix, the business continuity plan and quality assurance reports.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

Requires Improvement: Some aspects of the service were not always safe which meant there was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; learning lessons when things go wrong

- On day one of the focused inspection, we found the service had not assessed risks appropriately for people who were on crisis beds. This was a particular concern, as the provider had failed to learn from a recent death about the need to risk assess appropriately people who were coming in on a short stay.
- We also found that whilst the service had introduced a new criterion for crisis bed admissions, this remained insufficient in keeping people safe.
- People using the residential component of the service had risk assessments in place. However, these did not contain information on what action to take should the risk occur.
- The service did not complete their own comprehensive initial assessment. They relied on documentation provided by the external crisis team. This meant that they were not assured the information was always accurate and up to date.
- There was no clear understanding of 'risks', with different descriptions being presented for one risk type. This meant that people that may not be suitable for the crisis bed were being accepted without a full understanding of their health needs. This in turn meant people were not always being kept safe.
- We discussed our concerns with the registered manager, and senior management team. Specifically, the need to appropriately assess risks and, where necessary, ensure staff had enough knowledge to keep people safe.
- We found that management within the home did not have an agreed approach to risk management, which led to confusion. This highlighted the need for clear guidelines and appropriate training and understanding of mental health issues.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- By day two of the inspection, an advanced criterion had been developed with the area director having an oversight of all new crisis bed admissions. The service had ensured all risks had been assessed and records illustrated reviews were to take place monthly.
- Training was booked for staff to attend. The service was considering implementing more face to face training to enable staff to raise questions and therefore further their knowledge interactively.
- Environmental and general risk assessments were in place, and regularly updated and reviewed.
- Accident and incident records were maintained, detailing action taken and any investigations completed.
- The service had a business continuity plan in place. This looked at possible emergencies that could affect service operation, and detailed what course of action staff were to take.

Systems and processes to safeguard people from the risk of abuse

- People reported they felt safe.
- Staff knew how to recognise abuse, and protect people from the different types of abuse.
- Staff were able to describe what action they would take if they felt people were at risk.
- People stated they believed they could report any concerns and that staff would take the necessary action to safeguard people.

Staffing and recruitment

- Sufficient staff were employed by the service. One person told us, "There's enough staff here who can help and offer support."
- Staff reported that there was enough staff on shift to ensure people's needs were met safely.
- Recruitment checks were completed to ensure appropriate staff were employed to work with people.

Using medicines safely

- Staff were trained in medicine management, with evidence of competency assessments being completed annually to ensure staff remained knowledge in administering medicines safely.
- Medicine administration records were up to date, and had been completed correctly.
- 'As required' medicines had comprehensive guidelines in place. This meant staff had sufficient information on when these were to be administered.
- Medicines were stored safely and securely, within locked cabinets. Temperatures were maintained to ensure the efficacy of medicines was not compromised.

Preventing and controlling infection

- Staff were trained in infection control.
- Where required personal protective equipment was provided and used by staff.
- Cleaning products and equipment was colour coded, to prevent the possibility of cross contamination from one area to another.
- Checks were completed as required, and showed what action was taken where required.

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture
Requires Improvement: Service management and leadership was inconsistent in understanding of risk and ensuring accurate governance. This meant that support may not always be delivered of high-quality, person-centred care, that was responsive to meeting a person's specific needs.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The service had a registered manager, as required.
- Whilst the registered manager was aware of their legal responsibility for meeting the requirements and regulations, they acknowledged that they had not fully ensured that the necessary risk assessments and care plan documentation had been developed from the onset of a person's admission.
- The registered provider had not always taken the necessary steps to assess, monitor and mitigate the risks relating to the health, safety and welfare of people.
- By day two, documentation has been completed, which accurately identified people's care and support needs. Where risks were identified, mitigating factors were written as guidance for staff.
- The registration regulations were met by the registered manager. The Commission were sent notification where required.
- Audits were completed frequently and had been amended to include focusing on different elements of care documentation.

Continuous learning and improving care

- The training matrix identified that a rolling training programme was offered to staff. However, staff and management acknowledged there were gaps within this.
- Learning was predominantly self-directed through e-learning. Staff felt this did not allow an opportunity to discuss issues and gain a full understanding of areas. The registered manager said they would be taking this point back to senior management, with the view of more 'classroom training' being provided.
- Staff were not trained in all specialist areas that they were delivering support in, as part of the mandatory training. We found that some training had been set up after the recent death. However, people were still being accepted to the service who had these complex behaviours and needs. This had not been identified by the provider's own systems and processes for assessing, monitoring and improving the quality and safety of the care provided.

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

- People were complimentary of the service, and said management listened to their views.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- The service and the registered manager were described as, "open and transparent" by people.
- Staff reported that the registered manager and deputy manager was accessible and approachable. They dealt with issues and concerns promptly when raised.
- People reported they were included in making decisions about their care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The service ensured quality assurance surveys were sent out annually to ask people, visitors and stakeholders what was good and what needed improving within the service .Action plans were developed and an update was provided to illustrate improvements as and when made.
- Staff were trained in the Equality and Human Right Act, as part of their mandatory training. The principles of these were applied in practice.
- Care plans covered areas of cultural, religious, sexuality support where people requested support.
- The provider ensured that staff too were treated in line with the principles of equality acts. Staff reported they were treated with respect, and with equality.

Working in partnership with others

- The service worked well with external agencies, specifically the crisis intervention team, who liaised with the home daily for all crisis bed admissions. However, it was recognised that people who were on a crisis bed were not always admitted with the correct paperwork.
- By day two of the inspection, paperwork had been developed by the provider, to ensure that people under their registration had the necessary documentation in place.