United Response

United Response - 47 Doublegates Green

Inspection report

47 Doublegates Green, Ripon,
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Date of inspection visit: 5 February 2015
Date of publication: 20/04/2015

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?	Good
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 5 February 2015. Because it is a small service we contacted the registered manager the day before the inspection to check that people would be in.

United Response – 47 Doublegates Green is a care home registered for up to 5 people with a learning disability. It is a large purpose built bungalow situated approximately one and a half miles from the centre of Ripon. The bungalow has five large, single bedrooms and two spacious bathrooms. The building has been designed to support people with complex needs and mobility difficulties. There is an enclosed, wheelchair accessible garden outside to the rear and parking to the front. At the time of our inspection there were 5 people living there.

There was a registered manager in post at the time of our inspection. 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 and associated Regulations about how the service is run.

We have told the provider to take action to make improvements in a number of areas.

We identified that there were risks to people's safety in the service. Some areas of the service, such as the kitchen, had not been maintained adequately and there were infection control risks in bathrooms and toilets. We also found an error in the recording of one person's medicine. These risks had not been identified by the manager through the checks that took place to monitor the quality of the service.

The manager and staff were aware of the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). DoLS are safeguards put in place to protect people where their freedom of movement is restricted. All of the people at 47 Doublegates Green had a DoLS authorisation due to their restricted mobility. However, we found a number of decisions about care and treatment had been made without regard to the MCA.

Staff were knowledgeable about the people they supported and received the training they needed to support them in their roles. Staff had a good understanding of each person's needs and preferences. They spoke with people sensitively and in a caring manner. There was clear information in care plans about how people liked to communicate and this was followed through in practice. People had good opportunities to participate in community activities in line with their particular interests. People were supported to lead fulfilling lives in line with their own preferences and choices

People were supported in having their day to day health needs met. Health services such as dentists, GPs and opticians were used as required and there were close links with other services such as the local North Yorkshire County Council Learning Disability Team. People were given a variety of healthy meals as part of their diet which were prepared according to their individual needs.

Staff had received training in safeguarding and told us they were confident about their responsibilities should abuse be suspected. Staffing levels were sufficient to keep people safe, however there had been occasions where the staff team were placed under pressure to provide sufficient cover due to sickness and absence. This was being monitored by the manager.

There was a caring and supportive culture in the service which was based around giving people fulfilling lives. The staff team were focussed on delivering care and support which met people's needs in a person centred way.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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 safe.

People were not fully protected by risks relating to the environment, infection control and medicine administration.

Staff had been trained in safeguarding awareness and were confident about their responsibilities should abuse be suspected.

Staff were suitably qualified and experienced. There were enough staff on duty to keep people safe.

Requires improvement 

Is the service effective?
The service was not effective.

People's consent to care and treatment was not always gained in line with relevant legislation.

Staff were knowledgeable about people's needs and had the training they needed to support them in their roles.

People were supported to maintain good health and had sufficient amounts of food and drink through a varied diet.

Requires improvement 

Is the service caring?
The service was caring.

There were good relationships between staff and people who used the service. The atmosphere was caring and friendly. People were treated with respect and dignity.

Staff knew people well and understood how to communicate with people. Relatives and advocates were involved in making decisions about care and treatment.

Good 

Is the service responsive?
The service was responsive.

People received person centred care. Care records contained good information about people's preferences, likes and dislikes.

Staff demonstrated a good understanding of how people could communicate through body language and the use of sounds. Relatives and other representatives were able to raise concerns and these were acted on.

Good 

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

Requires improvement 

Summary of findings

The management systems in place for making sure the service was operating safely were not effective. The processes for monitoring and reviewing improvement did not provide clear instruction for staff.

There was a positive, caring culture in the service which focussed on the needs of individuals.

United Response - 47 Doublegates 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.

We last inspected the service in November 2013 where it was found to be meeting the required standards.

This inspection took place on 5 February 2015. Because it is a small service we contacted the registered manager the day before the inspection to check that people would be in. The inspection was carried out by one inspector.

Before the inspection we reviewed the information we held about the service. This included notifications regarding safeguarding, accidents and changes which the provider had informed us about. A notification is information about important events which the service is required to send us by law. We also looked at previous inspection reports. We were unable to review a Provider Information Record (PIR) as one had not been requested for this service. The PIR 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.

During this inspection we looked around the premises, spent time with people in their rooms and in the lounge/ dining room. We looked at records which related to people's individual care. We looked at two people's care planning documentation and other records associated with running a care home. This included two recruitment records, training records, the staff rota, notifications and records of meetings.

We spoke with five members of staff and the registered manager. Because people who used the service had complex needs they were not able to tell us about their experiences. We observed how people led their lives during the day and the support that they were given by staff. We also spoke with two representatives of people over the phone after the inspection as well as a visiting professional.

Requires improvement

Is the service safe?

Our findings

There was information on the office wall about keeping people safe as well as safeguarding procedures. Staff had received training in the safeguarding of adults. This was confirmed by one staff member who said "I have had safeguarding training. If I have any concerns I will approach a manager. I know about whistleblowing and I'm confident about going higher [in the organisation]". Staff were confident about identifying potential abuse and knew what action to take.

Accident and incident forms had been completed as necessary. The manager explained that these were sent to Head Office each month so that the provider could monitor the level of incidents at the service. We saw that these forms had been completed accurately. However, they did not direct staff to consider when an incident might be seen as a safeguarding concern or if any learning had been identified as a result.

Each person's care plan contained details of their prescribed medicines including what it was for, possible side effects and how they preferred to take them. Medicines were stored in a locked cupboard area. Most medicines were received from a pharmacist in blister packs. Other medicines, such as creams and 'as required' medicine were stored in a locked cabinet. Each person had a (MAR) which was signed by staff when medicine had been given. We found no unexplained gaps in recording on MAR charts.

Some people required medicine to manage an epileptic seizure. There were support guidelines in place for how to use the medicine and there was a list of authorised staff who had been trained to use the medicine correctly. One person's medicine administration record (MAR) for February 2015 did not include this medicine. A different medicine which they did not use had been recorded instead. When we queried this with the manager he confirmed that this must have been a pharmacy error but it had not been picked up by staff when the medicines had been received. We could see that this was an 'as required' medicine and there had been no reason to administer it during February 2015. However, although there was an up to date medicines policy in place which included the receipt, storage and disposal of medicines the error had not been identified. This meant that the systems in place did not protect people from the unsafe use 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.

Some areas of the toilets and bathrooms were not properly clean and presented a risk of cross infection. Three toilet seats were found to be dirty, one of which was also broken and loose. The cistern for one toilet had a piece broken off. We were told by the manager that there was no specific policy on infection control. This meant there was not an effective system to assess the risk of and prevent cross infection. This was in breach of regulation 12 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.

All other parts of the service, including the laundry area appeared clean and hygienic. Day and night staff were responsible for carrying out cleaning tasks in the service. Personal protective equipment such as disposable gloves and aprons was available when needed and red bags were available for separating any soiled laundry. The manager also said that although there was no specific training on infection control it was included within the training for health and safety and food hygiene which, we saw, staff had completed.

Health and safety checks relating to gas, electrics and water had been carried out and fire systems were inspected as necessary. Although corridors and most communal areas were free from observable hazards, we found that there were unsafe cupboard doors in the kitchen. When we opened one cupboard it swung down on one hinge nearly causing an injury. There was no sign to say that the cupboard was unsafe. Staff showed us another door which was broken and explained that although there was a system for reporting repairs, the kitchen cupboards were frequently broken. This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Any risks associated with people's day to day needs had been identified and there were clear, up to date risk assessments in place. These covered areas such as mobility, eating and drinking, medication and epilepsy. Risk assessments included preventative measures to make

Requires improvement

Is the service safe?

sure that risk were kept to a minimum. There were clear plans in place to protect people in the event of an emergency. These included emergency fire evacuation plans for each person and a disaster plan.

Staff told us that there were sufficient numbers of staff on duty to meet people's care needs but that it was sometimes "Difficult". Comments included "We can't really do what we would like. There are enough staff to meet people's needs but not enough for the 'little extras'", "Staffing is sometimes short. Sometimes only two staff. If someone is sick it gets very difficult" and "I feel it is safe". We noted that there was an on-call system if support was needed in an emergency.

The manager told us that there was no dependency tool which calculated staffing levels and that these were decided depending on what was going on. They said that there were usually three care staff on duty in the day and one sleep in with one waking night staff at night. However, the rota showed that there were often occasions where only two care staff were on duty during the day. For example, in January 2015 there were a high number of days with two care staff on duty including most weekends. On the day of our inspection there were two care staff on duty with one member of staff shadowing as they were new. The manager confirmed that there had been difficulty in maintaining staffing levels recently due to absence, but that the situation was now improving.

The manager told us that the recruitment records for staff were held at the Head Office. However, a checklist form was kept at the service which showed that the necessary checks had taken place before staff were offered employment. Records showed that all staff received a satisfactory criminal background check before starting work. Other checks included references and proof of identity. This meant that the provider could be certain that staff were of suitable background and character to work with vulnerable people.

Requires improvement

Is the service effective?

Our findings

Staff had received training in the Mental Capacity Act 2005 (MCA) as well as Deprivation of Liberty Safeguards (DoLS). The staff we spoke with had a clear understanding of what to do if a person did not have capacity to consent to a decision. One staff member said "I know that capacity can change and it needs to be reviewed".

However, we found that some decisions about care practice had not been agreed in line with the MCA. For example, one person had bed rails to prevent them from slipping out of bed. The person lacked capacity to make a decision to agree to the use of bed rails but a mental capacity assessment had not been completed. A 'best interest' meeting had not been held on their behalf. A best interest meeting is held when a person does not have the mental capacity to make a particular decision for themselves. It is a meeting of those who know the person well, such as relatives, or professionals involved in their care. A decision is then made based on what is felt to be in the best interest of the person.

Another person had a 'baby monitor' in their room due to the risks of them having an epileptic seizure. We noted that the monitor was on at all times and was heard from the lounge area. The manager told us that this had been requested by relatives and agreed by a GP. However, no mental capacity assessment had been completed regarding to the person's ability to consent to the monitor. A 'best interest' meeting had not been held. Another person had a Do Not Attempt Resuscitation form in their care records dated October 2012. This had not been agreed through a best interest meeting and had not been reviewed. The manager said it related to a stay in hospital and that it was no longer required and agreed to remove it.

The failure to act under the requirements of the MCA was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care records contained clear information about how to support them in making day to day decisions. This included information about how to present choice, the best time to ask, and when was not a good time. Staff feedback demonstrated that they were aware of these guidelines. The manager explained that because of people's complex needs, consent to care is often 'implied'. For example, when offering a bath, if a person appears happy then they are consenting to the care.

There was DoLS authorisation in place for each person due to their restricted mobility and need for staff supervision. The manager was aware of recent legal guidance around DoLS and how this impacted on the service.

Staff told us that they got the training they needed to support them in their roles. Core training was provided in areas such as health and safety, manual handling and safeguarding and that this was kept up to date and refreshed as necessary. Specialist training was also provided to support with people's individual needs. This included epilepsy training and challenging behaviour awareness. One staff member told us "Company training is good. I've just completed an NVQ3 [National Vocational Qualification] in care. I get the training I need".

One member of staff who had recently started working at the service talked about their induction. They said that they visited the home before starting in order to introduce themselves and gain a better awareness of the needs of people that lived there. They were currently shadowing other staff on duty in order to become familiar with working practice and how to support people. They told us "It's very organised here. Support plans have a lot of useful information".

Staff told us that there was good team work and they felt supported. One staff member said "I have a 1-1 [with the manager] usually once a month. I feel listened to and that issues are acted on". Records showed that staff had regular opportunities to have a formal supervision meeting with the manager to discuss work issues and personal development.

People's care records contained information about health needs and how these were to be met. The manager told us that they were in the process of developing a Health Action Plan for each person so that the information was all in one document. Because people had complex health needs there was close involvement with other professionals such as a GP, district nurse and learning disability team. There was evidence that where health concerns had been identified, appropriate action had been taken.

Although a record was kept of one person's food and fluid intake, there was no guidance about recommended daily

Requires improvement

Is the service effective?

targets and the amounts were not totalled each day. There was no guidance about what action staff should take if they had any concerns. The manager showed us evidence that this person had been referred to a GP after refusing to eat at mealtimes in January. This showed that an issue had been identified and action taken. However, this was as a result of staff experience rather than clear written guidance.

We were also told that no daily care records or progress notes were maintained for people. This meant there was a risk that any patterns or changes in needs would not be identified and it was difficult to review and evaluate progress towards goals.

People were supported to maintain a balanced diet. Care plans contained clear guidance on people's needs and preferences for eating and drinking. All of the people required assistance with eating had either soft/pureed food or food that was finely chopped. A staff member told us that they cooked food fresh for each meal and it was then prepared for each person as required. Menus showed that there was a range of healthy and nutritious meals which provided a varied diet.

People's individual needs were met by the design of the environment. The building was purpose built for people with mobility difficulties. Corridors were wide and communal rooms were spacious providing sufficient room for wheelchairs. People's bedrooms had plenty of space so that manual handling could take place safely. Specialist equipment such as ceiling hoists had been provided to some people. There were also special baths and hoists in bathrooms which meant that people could be supported with personal care safely and in a way that met their needs.

Good

Is the service caring?

Our findings

Representatives of people who used the service were positive about the care. Comments included “All the staff are extremely helpful. I can’t fault them. They have been very good” and “There is good care. We know [name] is happy. It’s the best place [name] has lived in”. A professional who visits the service told us “My client receives great care. Staff are caring and gentle”. One member of staff explained “We try to make it a home. It’s a nice place”.

Throughout the inspection we observed that staff supported people with kindness and a sensitivity to their needs and level of understanding. It was clear that staff understood people’s preferences and how they liked to be supported. This knowledge had been built up in the team through experience; sharing ideas and discussing what approaches have been successful or not.

The manager explained that because people had complex needs, particularly around communication, the staff team would ‘best guess’ what to do when a person was indicating they required support. This was achieved by building up a history of each person, understanding body language and verbal sounds as well as feedback from relatives, advocates and professionals. Staff confirmed this and gave examples, such as one person’s behaviour when they heard the kettle boiling, which indicated they wanted a drink.

We noted that although care plans included information on communication and what people’s behaviour might mean, staff had a greater awareness than that which had been recorded. This meant that the knowledge and experience of the staff team was not fully utilised to make sure that care plans were as detailed as possible for those less familiar with people at the service.

Care plans contained clear guidance on how people should be involved in their care wherever possible. Guidance covered areas such as getting up and going to bed, personal care and outings.

The manager told us that it was difficult to involve people in making decisions about their care because of their complex needs. Each person had a representative such as a relative or advocate who was able to speak on their behalf. We could see from care records and reviews that representatives were involved in decisions. Those we spoke with said “I’m involved in anything important around welfare. There are annual reviews” and “Staff are approachable and have [name] best interest at heart”. Representatives said they were able to visit when they wanted.

We observed that people were treated with respect by staff. People were called by the name they preferred and staff remained attentive whilst carrying out day to day tasks such as laundry and cooking. One person used a wheelchair and liked to roam the building independently. Staff respected this by observing from a short distance and only stepping in when the person disturbed other people’s privacy. When personal care was provided we observed that this was carried out in private to ensure people’s dignity was maintained.

Good

Is the service responsive?

Our findings

Care plans contained clear information about people's preferences for support. Relatives, advocates and professionals had been asked to contribute to information and support guidance in order to get a good overview of people's needs. There were specific, personalised instructions regarding how to give choices, what was important, how to support each person and how to communicate. Some of the information used photographs of a task or activity to show exactly how people needed support, such as with laundry or baking. People had comprehensive, yearly reviews which covered all areas of their life such as home life, community life, relationships and goals. Professionals, such as a community nurse or speech and language therapist were asked to contribute as were representatives.

We noted a form in one person's profile called a '4 and 1 Question'. This was a way of recording what had been tried with a person, how successful it was and the action taken as a result. For example, it was seen that a person made use of an overhead television while in hospital. As a result of recording the information, a request was made for funding and the person was provided with a similar television to use in their room. This showed that the service responded to identified needs to improve people's lives. A member of staff told us "We get to know people. Individual preferences are encouraged and we try to do what they want. We try to respond to needs expressed through facial expressions and sounds".

People were supported to take part in a range of activities. These included hydrotherapy, shopping, clubs, and sensory sessions. A 'music man' came to visit the service regularly and, as part of the visit, spent time with one person in their room singing and playing the guitar. Staff told us this was something the person particularly enjoyed. One staff member said "We do lots of activities. We get involved in the community". The manager told us it was important for people to be visible in the community to avoid isolation, and described how he had been working with the local Post Office to improve accessibility there. During our inspection we noted that most people got out at some point during the day.

An up to date complaints policy was in place which recognised that complaining could be difficult for a person with complex needs. The policy included the statement "A person who presents challenging behaviour may be using that behaviour to tell us what they want – or what they don't want. It may be the only method they have of complaining". The manager told us that generally they relied on representatives such as relatives or advocates to raise a complaint on people's behalf, but none had been received in the past year. One representative told us "If I have a problem I tell the manager. He usually sorts it". The complaints policy included the right of people to contact the CQC if they preferred.

Requires improvement

Is the service well-led?

Our findings

We identified a number of areas of practice that potentially placed people at risk. These included errors in the medication system and environmental risks. Although the manager carried out a number of checks intended to monitor the quality of the service and identify risks and areas for improvement, these had not identified the potential risks found in this inspection. There was a failure in quality monitoring systems to identify these concerns and take appropriate action. 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.

The provider carried out a number of different audits to monitor the quality of the service. Every three months a senior manager or manager from another service visited to look at different parts of the service, including risk assessments, health and safety and staffing. Any areas for improvement were noted and reviewed at the next visit. We also saw a report from a visit in February 2014 by a person with a learning disability to look at the service from the perspective of a service user.

Staff talked to us about the culture in the service. Comments included “The atmosphere is open here”, “People are treated as individuals” and “We try to achieve a good quality of life. Try to give people as many experiences as possible”. The manager said “We try to keep people busy. We use a person centred approach”. During our inspection we observed a caring and inclusive approach by the staff. Staff were careful to include people in general conversations and the atmosphere was light hearted and friendly. Although staff were clearly busy they were able to make sure that people got out in to the community and took part in activities.

The manager described how the culture was promoted in the team. He explained that was achieved through good teamwork, supported by care planning which focussed on the individual and how to involve them. Team meetings, supervisions and yearly appraisals were used to talk about people and review staff development in line with organisational expectations.

Although we saw that team meetings took place regularly, the records of meetings were very brief. Minutes only gave the details of topics discussed and there were no details about decisions made or agreed actions. This meant that there was no clear way of reviewing previous decisions and progress against agreed goals. It also meant that staff who were unable to attend had to rely on verbal feedback. This did not provide clear information to staff about management expectations.

Staff had opportunities to raise service development issues with the provider. One staff member talked about a meeting which they attended every three months called United Voice. This was a meeting of staff representatives from different services in the organisation to discuss issues about the support of people. They told us it was a useful meeting and explained “It makes a difference. It goes to the directors”.

The provider completed an annual quality assurance survey which included representatives of people who used the service. The survey for 2014 was created in line with CQC’s new methodology to look at the domains safe, effective, responsive, caring and well-led. An accessible version was available for people with learning disabilities. We looked at the survey report for 2014 which summarised the responses and included organisational actions for the next year. This demonstrated that feedback from people and their representatives was used to inform future organisational priorities.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Inaccurate medicine records meant that service users were not protected against the risks associated with the management of medicines. Regulation 12(f)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Infection control systems did not protect service users and others from the risks of cross infection. Regulation 12(2)(h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Service users and others were not protected from the risks of unsafe premises because of inadequate maintenance. Regulation 15.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person did not always act in accordance with legislation to gain the consent of service users in relation to their care and treatment. Regulation 11.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Service users were not protected by the systems in place to assess and monitor risks relating to health and safety. Regulation 17.