Connor Associates Limited

Holywell Home

Inspection report

17 West End Road
Morecambe
Lancashire
LA4 4DJ

Date of inspection visit:
29 July 2016

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28 September 2016

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 08 and 27 April 2016, at which four breaches of legal requirements were found. This was because the provider did not take effective preventative action to manage risk and keep people safe. Suitable systems were not in place to monitor and mitigate the risks to people who lived at the home. We also found the provider did not maintain an accurate and complete record of the care provided to instruct staff and minimise risk.

Following the inspection, we took enforcement action as the provider did not ensure there were enough staff to respond to the changing needs and circumstances of people requiring support. They also failed in their duty to notify the Care Quality Commission (CQC) about events they were required to.

After the comprehensive inspection in April 2016, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches and enforcement action. We carried out this unannounced focused inspection on the 29 July 2016 to check they had followed their plan and to confirm they now met legal requirements. This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Holywell Home on our website at www.cqc.org.uk'.

Holywell Home provides personal care and accommodation for up to six adults with a learning disability. The home is situated at the West End of Morecambe, close to the promenade and within easy access to local amenities. There are two communal lounges, one on the lower ground floor and one on the first floor. There is also a combined kitchen and dining room on the lower ground floor. There is no lift therefore the home is not suitable for people who cannot manage stairs. At the time of our inspection, five people lived at Holywell Home.

A registered manager was not in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The provider was awaiting their Disclosure and Barring Service (DBS) clearance before submitting their application to become the registered manager. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups of people.

At our focused inspection on the 29 July 2016, we found improvements had been made. We saw documentation that indicated staffing levels were safe. The provider had systems to respond to unplanned staff absence. We saw safeguards were in place to manage risk.

Information we looked at in people's care records reflected the current needs of people being supported and informed staff how to support them.

We read the diary sheets written by staff concerning people who lived at Holywell Home. We found no evidence incidents went unreported to the Commission.

We could not improve the rating for safe and well led from inadequate because to do so requires consistent good practice over time. We could not improve the rating for responsive from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

We found action had been taken to improve the safety of people living at the service.

Authorisation to restrict people's liberty had been approved. Care plans and risk assessments were up to date and identified hazards to people's safety and how to support them.

Two people required support when they left the service. Strategies were in place to ensure they received their one to one support to keep them safe. Guidelines clearly stated which people could not go out unaccompanied.

We could not improve the rating for safe from Inadequate because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service responsive?

Requires Improvement

We found action had been taken to improve the responsiveness of the service.

Action had been taken to review and update care plans and risk assessments to allow staff to respond in a person centred way.

We could not improve the rating for responsive from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service well-led?

Inadequate

We found action had been taken to improve good management of the service.

The provider had led the management team in reviewing and updating people's care plans.

The provider had worked with the local authority and CQC to introduce new ways of working for staff to keep people safe.

We could not improve the rating for well-led from inadequate because to do so requires consistent good practice over time.

Holywell 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 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 undertook an unannounced focused inspection of Holywell Home on 29 July 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 08 and 27 April inspection had been made. The team inspected the service against three of the five questions we ask about services: is the service safe, is the service responsive and is the service well-led. This is because the service was not meeting some legal requirements.

The inspection team consisted of an adult social care inspector.

Prior to this inspection, we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are submitted to the Care Quality Commission and tell us about important events the provider is required to send us. This helped us to gain a balanced overview of what people experienced accessing the service.

We spoke with a range of people about this service. They included three people who lived at the home, two relatives, the manager and two staff. We checked documents in relation to two people who lived at Holywell Home.

Inadequate

Is the service safe?

Our findings

At our comprehensive inspection of Holywell Home on 08 and 27 April 2016, we found the provider did not safely manage the risks to people they supported. This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not take effective preventative action to keep people safe. We noted, and reported, the provider failed to take action to manage unplanned staff absence. This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not ensure there was enough staff to respond to the changing needs and circumstances of people requiring support.

During our inspection visit on 29 July 2016, we looked at what safeguards the provider had to manage the risks and keep people safe. At the front of the building, there were two doors, which opened onto the street. The doors were now locked and people, who required support, were accompanied when leaving the building. One person who lived at the home told us, "The doors are always locked." A second person confirmed, "The doors are locked and I have a key that lets me in and out." During this inspection, we observed people who had been assessed as safe to do so, leave and return home. They unlocked and locked the door on leaving and repeated the process when they returned home. We spoke with a new member of staff and asked if anyone had informed them the exit doors needed to be locked. They told us, "I think everybody has told me to keep the doors locked. They have emphasised the importance of keeping the doors locked."

We read care plans and up–to-date risk assessments that identified the need for the exit doors to be locked to keep two people safe. We noted when restrictions were placed upon people who lacked mental capacity applications to deprive them lawfully of their liberty had been submitted to the supervisory body and authorised. The staff team had signed the authorisation indicating they understood the restrictions to keep people safe. The manager and deputy manager were both aware of the need to review regularly the needs of people when restrictions were placed upon them. We spoke with two relatives who told us they had been consulted about the decision to restrict their family member's liberty. During our inspection, we saw paperwork that showed the provider was working with the local authority in managing the risks to people's safety. This demonstrated the provider was following the processes to work in people's best interest ensuring their rights were protected.

At this focused inspection, we looked at eight weeks staff rotas for evidence people were receiving their one-to-one support. We saw written evidence that staff had been identified to deliver one-to- one support. We spoke with one person and two of their relatives about their one- to-one support. They confirmed their support was in place. On our unannounced visit, we noted the staffing levels matched what was documented on the rota. We saw changes of staff had been documented half way through a shift on several days. A member of the management team told us this was due to sickness or other commitments. They told us, they now had back up staff they could call on should they be required and the change of staffing mid shift was evidence of this. We looked at team meeting minutes where protocols to follow in the event of unplanned staff absence had been discussed. This showed the provider had a system to ensure staffing levels met people's needs and kept them safe.

Requires Improvement

Is the service responsive?

Our findings

At our comprehensive inspection of Holywell Home on 08 and 27 April 2016, we found the provider did not safely manage the risks to people they supported. This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not maintain an accurate and complete record of the care provided to instruct staff and minimise risk.

During our inspection visit on 29 July 2016, we looked at two people's care plans. At our last inspection, we saw guidelines in some care records contained contradictory
Information. At this visit, we saw improvements had been made. Care plans included sections on communication, medication, mental health, personal care and mobility. The information in the plans reflected the current needs of people being supported, and how to support them. Staff members had signed and dated the care plans, which indicated they had read and understood them.

We saw the provider had given guidance to staff on how to write detailed notes. The notes should reflect what the person had experienced that day. For example, the guidance included, 'what did they say?', 'what did you say?', 'where did you go?' The guidance emphasised writing in detail and not one word recording. It explained detailed recording was to reduce the risk of misconceptions taking place. We looked at recent staff notes and these had additional personalised information related to people's activities mood and location within the home. This showed the provider had taken action to ensure people's care plans were an accurate and current record of their support needs.

Inadequate

Is the service well-led?

Our findings

At our comprehensive inspection of Holywell Home on 08 and 27 April 2016, we found the provider had not reported allegations of abuse and other incidents to CQC. We noted safeguarding incidents had gone unreported. The provider had not completed the necessary notifications that related to these incidents. The provider had discussed the incidents with CQC and the local authority, but not submitted the relevant notifications. This was a breach of Regulation 18 Health and Social Care Act 2008 (Registration of Regulated Activities) Regulations 2009, because the provider had failed in its regulatory duty to notify CQC about important events they are required to send.

At the comprehensive inspection on 08 and 27 April 2016, we noted concerns about the staffing arrangements for providing one- to-one support and how risks to people who lived at the home were managed and recorded. We found safeguards made in peoples' best interests had not been followed in every case. This was a breach of Regulation 17, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because robust systems were not in place to monitor and mitigate the risks to people who lived at the home.

During the inspection carried out on 29 July 2016, we read daily diary sheets for two people covering an eight week period. We did not find any documented incidents of abuse or incidents that affected the health and wellbeing of people who lived at Holywell Home. We found no evidence incidents went unreported to the commission or local authority.

At this inspection, we discussed regulatory responsibilities with the manager on what should be notified to CQC. They were fully aware on what and when to submit notifications.

We read care plans and up–to-date risk assessments that identified the need for the exit doors to be locked to keep two people safe. We noted the provider had safeguards in place to manage unexpected staff absence. Rotas we looked at showed the safeguards had been instigated to ensure people received their allocated one-to-one hours to keep them safe. We saw the provider had introduced contact sheets for staff to sign. The contact sheet is signed by staff to show they have confirmed the whereabouts of one person who lived at the home. Staff had to monitor where the person was very regularly throughout the day. This was in the person's best interest and ensured the person had not left the home unsupported. This showed the provider had a framework in place to guide staff to minimise risk and keep people safe.