Parkcare Homes (No.2) Limited

Ashridge

Inspection report

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Date of inspection visit:
13 June 2016

Date of publication:
12 September 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 13 June 2016 and was unannounced.

The home is located close to the centre of Boston and is registered to provide accommodation with personal care for 18 people who are living with a learning disability or autism. There were 17 people living at the home when we inspected. There was a bungalow attached to the home and the six people who lived in the bungalow were able to live more independently.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect themselves. People's abilities to make decisions were assessed and where necessary DoLS authorisations were in place.

The registered manager was well liked by people living at the home and staff. People had confidence that they could talk to them about any concerns and that the registered manager would support them. However, people did not have so much trust in other staff and at times felt that the staff did not listen to them.

People's care plans identified the risks to them. However, care plans did not fully identify the care needed to keep people safe. While staff had received training in keeping people safe from harm the lack of information in the care plans had put people at risk when accessing the community.

There were enough staff needed to meet people's needs and the provider had ensured that checks had been completed to ensure staff were of good character. Training was in place to support staff to develop the skills they needed to provide appropriate care to people. Staff were supported with supervisions which allowed them to identity shortfalls in training and any other support they needed. However, at times staff were focused on the systems needed to provide safe care and failed to ensure care was meeting people's individual needs.

People were supported to develop personal relationships and to know how to stay safe in a relationship. However, people were not always fully supported to explore their own personalities and lifestyle choices.

People were engaged in reviewing their care plans but at times felt staff did not always fully support them and did not always listen to what they were trying to say. Where individual staff support had been identified as needed to help people to be occupied during the day and to access the community this was in place.

However, more independent people were left to engage themselves in activities and may have benefitted from more support.

There was a set of audits in place to monitor the quality of the service provided and the registered manager had gathered the views of people using 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?

Requires Improvement

The service was not consistently safe.

Risks to people were identified; however, care plans did not fully help people to manage those risks.

Staff had received training in how to keep people safe from harm.

Medicines were safely managed; however they were not administered in a person centre manner.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported to have a choice of food and drink. However, systems to monitor if they were able to maintain a healthy weight were not always effective.

People had been supported to make decisions and staff had followed Mental Capapcity Act guidance to protect people's rights.

People were supported to access health care when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always supported to explore all aspects of their personality.

Staff were kind and caring and supported people to communicate using the most appropriate method for each person.

People's privacy was respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans did not always contain enough information to ensure people's needs were fully met.

There were some activities in place. However, some people were not fully supported in their activities and people were not always supported to access the community and local facilities.

Information was available to support people to make complaints. However, people felt at times the staff did not always listen to their concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People felt supported by the registered manager who was approachable and trusted. However, people felt other members of staff were not always so supportive.

Used furniture and equipment was not safely removed from the premises.

People had been asked for their views on the care they received.

Ashridge

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 inspection took place on 13 June 2016 and was unannounced. The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home. This included any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the service. We also reviewed information sent to us by the local authority who commission care for some people living at the home. Before the 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.

During the inspection we spoke with eight people who lived at the home and a visiting relative. We also spoke to the registered manager, deputy manager, senior care worker and a care worker and spent time observing care.

We looked at three care plans and other records which recorded the care people received. In addition we examined records relating to how the service was run including staffing, training and quality assurance.

Requires Improvement

Is the service safe?

Our findings

There had been a number of safeguarding incidents at the home since our last inspection. The majority of concerns had arisen in May 2016 and June 2016. Most of these incidents had been minor disputes between people living at the home and were quickly resolved. We also saw that there had been some safeguarding concerns raised about people when they accessed the community. On each occasion the registered manager had engaged with the relevant authorities to keep people safe from harm. However, the number of this type of incidents was higher than we would expect from this type of care home.

Although staff we spoke with had received training in how to keep people safe and knew how to raise concerns, people told us that at times they did not feel safe. One person told us, "Some people are bullies… I told staff and they didn't do [anything] for me." They told us that they had raised concerns with one member of staff who had told them they did not want to get involved. Another person told us they only felt safe when two particular members of staff were in the house. They told us, "I don't feel safe if they're not here I get awkward walking around the house."

Risks to people had been identified and some care had been planned to help to keep people safe. For example, people had mobile telephones so they could contact the home when they were out in the community. However, given the number of safeguarding incidents it was clear that the care plans did not support risks to be lessened adequately. We had particular concerns around the risk planning for when people accessed the community. For example, one person who accessed the community independently was more likely to engage in behaviours which put them at risk when they were distressed. There was no information in their care plans to show at these times more action was needed to keep them safe. In addition there was no exploration of if the person would still recognised the risks when distressed and respect the processes to keep them safe as identified in their care plan.

There were emergency evacuation plans in place to ensure that people received the correct support needed to keep them safe in the event of a fire. In addition the registered manager had taken action to ensure that all the information needed to keep people safe would be immediately available to the emergency services during an incident. Business continuity plans were also in place to ensure that there would be alternative accommodation and staff support available to people if needed. However, The registered manager had not identified the risks to people when disposing of equipment. Outside there was a pile of broken furniture and equipment such as beds and televisions, which were no longer in use. We saw that this had been placed in a pile in the garden. The area was not secured to prevent people from accessing it and was next to an area one person used as an allotment. This was unsightly and could be a danger to people. We discussed this with the registered manager who assured us that they would get the equipment removed and the areas cleaned up.

Medicines were managed safely. However, the way they were administered was task focused and did not support people to receive person centred care. We saw that at set times of the day the senior care staff administered medicines from the care office. Some of the people waited in the entrance hall to be called for their medicines. Instead of dealing with the people waiting first we saw that the process in place required

the member of staff to administer the medicines in the order the medicines administration record was ordered.

People had a good understanding of the medicines they were taking and why they needed them. One person we spoke to told us how staff supported them when they were concerned that their medicine did not have the desired effect. One person was supported to be independent with their medicines, although staff still performed with weekly checks to ensure that they were managing.

Systems were in place to manage the stock of medicines and to reorder it in a timely fashion so that people always had access to their medicines when they needed them. In addition the home had a stock of homely remedies for coughs, cold and pain relief. We saw each care plan contained information about the use of homely remedies.

The provider had systems in place to ensure they checked if people had the appropriate skills and qualifications to care for people before offering them employment at the service. For example, we saw people had completed application forms and the registered manager had completed structured interviews. The required checks had been completed to ensure that staff were safe to work with people who live at the service.

The registered manager had taken appropriate steps to identify the number of staff required to support people's needs. In addition they had worked with social services to maximise people's abilities to access the community. For example, two people had chosen to pool their one to one support hours. Where people need one to one support this was separately identified on the rota to ensure that it was always staffed appropriately. However, the registered manager told us that at nights they did not always have enough staff trained in administering medicines and that if a person needed their medicine they would have to wait until a senior member of staff responded to the on call systems.

Requires Improvement

Is the service effective?

Our findings

People who lived in the bungalow had their own kitchen and were independent with eating and drinking. They cooked their own meals each day with support from staff when needed. People living in the main home had their meals cooked for them, but they were able to access the kitchen independently to get drinks and snacks. People told us they were happy with the food offered.

One person living at the home had a limited list of food they would eat. The staff ensured that this food was offered to the person. However, because they were unsure if this would support the person to maintain a healthy weight they had also referred the person to the doctor for advice. The person was prescribed nutritional supplements to help them stay healthy. The deputy manager told us that they did not look like they had lost weight but that they had not been able to weigh the person due to their lack of mobility. The registered manager had not identified other methods of monitoring the person's weight to see if they were maintaining a healthy weight.

We saw that in another person's care plan it showed that they had lost over a stone in weight between January and March 2016. They had not had their weight recorded after March 2016 and so it was not possible to see if they had continued to lose weight. While the person appeared to be at a healthy weight we raised this with the deputy manager who told us they would ensure that the person was monitored.

Staff told us and records showed that staff were supported with appropriate training to support the needs of people living at the home. All new staff completed an induction which included completing computer based learning and shadowing an experienced member of staff. In addition new staff were supported to complete the care certificate. The care certificate is a national set of standards which contains the basic information staff need to support people safely. Staff told us that the registered manager checked they felt confident in their skills before allowing them to work independently.

Staff were also supported by refresher training at suitable intervals to ensure they kept their skills up to date and reflected the latest best practice. Furthermore staff were encouraged during their regular supervisions to identify if they had any areas where they wanted or needed further training.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions

on authorisations to deprive a person of their liberty were being met. The registered manager had appropriately assessed people's abilities to make a decision about where they lived and where necessary had made applications for people to be assessed under the deprivation of liberty safeguards. Where DoLS had been authorised for some people there were no conditions attached for staff to adhere to.

Where there were some concerns that people may not be able to make decisions for themselves appropriate assessments had been completed in line with the MCA 2005. Where people had been unable to make decisions for themselves they had been supported with decisions made in their best interests by family, staff and healthcare professionals.

Individual care plans included all the information needed to support people's day-to-day health needs. Additionally, we saw people had been supported to arrange and attend for eye tests and their prescriptions had been updated where necessary. Records showed other health professionals such as GP's, the community mental health team and speech and language therapists had been included in people's care when needed.

Health action plans were in place if the person needed to go to hospital to help hospital staff understand the person and their needs. When people went to hospital they were always accompanied by a member of staff. In addition the hospitals learning disabilities nurse was always informed that they were admitted to ensure further support and guidance was available.

Requires Improvement

Is the service caring?

Our findings

People were supported to have personal relationships and given the time and space to spend quality time with their partner. Care plans included information on people's relationships and how people could stay safe within close relationships. However, at times we saw that staff had not fully recognised the impact on people when their relationships broke down or helped people to work through their emotions. Records showed that there had been a number of incidents related to the breakdown of a relationship.

The provider did not demonstrate a good understanding of how to promote equality and diversity. For example, we saw that people were not fully supported to express their identity or to experiment with their clothing. In addition they were not supported to experiment in public and were reminded to keep certain behaviours in the privacy of their bedrooms to safeguard themselves from the reactions of other people who lived in the home. There was nothing in the person's care plan to show how they were supported to interact with other people who liked to dress in a similar manner or to explore this aspect of their personality.

We found that some areas of the home did were not well maintained and did not support people's dignity. For example, in the bungalow kitchen the drawer fronts were screwed into position and the kitchen chair backs were cracked. In addition the controls of the cooker were worn and more difficult for people to use.

Individual staff were kind and caring to people and used different methods of communication to help people make choices about their care. We saw staff using sign language to communicate with some people. Other people used pictures and symbols. For example, we could see pictures were used to offer people a choice of options for lunch.

People's care plans also contained pictures to help them understand they care they needed. However, the pictures used were small and pale and may not have fully supported people to understand their care plan. Care plans supported staff to understand people's communication abilities. For example, one person's care plan stated that they would need complex information reworded to ensure that they understood it.

The home had recently had two unexpected bereavements which had affected the people living at the home. The registered manager had arranged for people to receive bereavement counselling and had created a memorial in the garden. People living at the home told us about the memorial and how they visited it to remember their friends.

The provider supported people to know who was caring for them on a daily basis, However, this was in the management corridor and so people would have to make a special effort to go and look at the board. In a more central area of the home was a notice board with information for people about the care they received. For example, we saw that there was a leaflet on how to complain and information on the European referendum. One person living at the home had chosen to participate in the European referendum and staff had supported them and arranged for them to have information in a format which was accessible to them.

We saw one person's care recorded how they valued the privacy of their bedroom and that this was

important to them. The registered manager had set down clear guidelines for staff about when they could enter a person's room, for example, for health and safety checks.

Requires Improvement

Is the service responsive?

Our findings

A visiting relative told us, "I think you'll find it's a very good home. The party was lovely yesterday. Here my relative is up and about a lot more."

The registered manager explained how people were normally assessed before they moved into the home. In addition there was a slow transition which involved visits for coffee and meals and overnight stays before they moved in permanently. However, they had recently admitted one person in an emergency and had not completed an assessment before they moved into the home. They had not initially been fully equipped to manage the moving and handling and other care needs for this person. Staff had contacted us to tell us about how this had impacted on the other people living at the home as they were unable to supervise people properly. Since the admission staff had worked with the person to better understand their needs and to help them fit into the home.

There were care plans in place which described people's needs, although they did not always contain enough information to keep people safe. People had been fully involved with developing their care plans and knew about the information they contained. In addition monthly reviews monitored people's progress and allowed people to have set time each month to discuss their needs. People had key workers to support them. These are members of staff who work closely with the person to support them and get to know their individual needs. However, one person told us that they were not happy with their key worker as they felt they did not know them very well. They told us that the key worker didn't listen to them.

A recent fire assessment had identified a risk as one person was hoarding a lot of personal items in their bedroom and did not like to part with anything. In addition they were still bringing more possessions into the home on a regular basis. The registered manager had identified extra storage for this person to use. However, this did not resolve the person's emotional attachment to keeping things and when the new storage was full the issue would re-occur.

People's development needs had been identified through support from a local college and one person had been supported to get a part time volunteer role in a community shop. People were supported in activities of daily living such as cooking and cleaning.

Two people at the home had been identified as needing day care and this was provided in house by an activity co-ordinator. We saw that there was a planned timetable of activities for these people. We also saw that another member of staff was supporting three people in the dining room to do some colouring. Two of these people spent most of their day in the dining room and although they had their colouring books in front of them they were not showing an interest in them.

However, we saw that people were not always fully supported to engage in their hobbies and some people after completing their identified chores were wandering around the home. One person told us they felt with more support they could have better access to the community and do more things. They told us, "I've not got a bus pass, not got a cinema card I've told staff four or five times they never listen". One person had

spent time and effort creating an allotment out of an area of garden that the registered manager had said that they could use. We saw that they had planted some vegetables and had made a small rockery. However they had not been supported to develop or maintain the plot with appropriate resources or encouragement from staff.

We saw there was a notice telling people how to complain in the main entrance and care staff told us if anyone complained to them they would tell the shift leader or the registered manager. When we asked about complaints one person told us, "I'd tell the [registered] manager or deputy manager or I'd ring my social worker." We saw from the complaints log that complaints had been recorded and investigated. However, there appeared to be a lack of awareness for people that complaints had been resolved. For example, one person told us, "I tell the [registered] manager or the deputy manager and they don't hear what I say."

Requires Improvement

Is the service well-led?

Our findings

People living at the home told us that they respected and trusted the registered manager and that they could go and talk to them at any time and they would listen. However, the registered manager had been absent from the home for prolonged periods of time while they had supported the provider to manage other homes in the provider's organisations. People told us that this had left them unsettled and they felt better now that the registered manager was back at Ashridge. People did not have as much trust in the other members of staff and told us that staff didn't understand their needs and failed to support them in the things they wanted to do. They also said that while they talked to staff about concerns they had they felt at times staff did not really listen to what they were saying.

The registered manager recorded all the accidents and incidents that occurred in the home. This allowed them to review the information to see if there were any recurrent trends of why accidents and incidents were occurring. However, we saw at times some of the details were missing from the incident reports which may make identifying trends more difficult.

Staff told us that the registered manager was involved with the care people received and knew people's needs. Staff also told us that the registered manager was approachable and that they could go to them with any issue and the registered manager would try their best to resolve any problems. Staff were supported with monthly staff meetings. Staff were able to raise whistle blowing concerns and the registered manager took action when any concerns were raised with them. Whistle blowing is where staff can raise anonymous concerns if they are worried about the care provided.

People living at the home, their relatives and visiting health care professionals had been asked for their views on the care they received. We saw that the results were displayed on the notice board for people living at the home, relatives and visitors to see. The registered manger told us they were working on an action plan for areas which had been identified as needing action. In addition the provider held a regional residents' meeting where one person from each of the provider's homes in the region attended.

The registered manager had a set of audits to monitor the quality of the care provided to ensure that it met people's needs. For example, we saw that there were audits of the medicines and an infection control audit. We saw where action was identified as needed an action plan had been developed to ensure the corrective action was taken. The registered manager also had a quarterly health and safety meeting with people living at the home to ensure they were aware of the environmental risks in the home. In addition to the checks completed by the registered manager a regional manager visited the home on a regular basis to review the standard of care people received. They completed spot checks on people's support plans and the environment and spent time speaking to the people living at the home to see if they were happy with the care they received.