Holbeach & East Elloe Hospital Trust

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Inspection report

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Ratings

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

Overall summary

This was an unannounced inspection carried out on 24 June 2015. Holbeach and East Elloe Hospital Trust is a charity owned service. It has a council of members who are elected to oversee the running of the service. The service provides accommodation for up to 38 people who require residential or nursing care and also supports people living with dementia. The service has a six bedded GP respite unit within this number. There were 38 people living in the service when we carried out our inspection.

There was not a registered manager post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager had been recruited to the service and had submitted their application to become registered with the commission.

Summary of findings

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. At the time of our inspection no one was currently subject to an active DoLS authorisation.

Staff knew how to recognise and report any concerns so that people were kept safe from harm and background checks had been completed before new staff were appointed. Staff helped people to avoid having accidents, however, not all care documentation was completed which meant staff did not have access to important information about a person.

There were arrangements in place for ordering and disposing of medicines. However, people did not reliably receive their medicines. Some of the checks which the registered provider said needed to be made when medicines were dispensed had not been completed.

People had been helped to eat and drink enough to stay well. We found that people were provided with a choice of meals. When necessary, people were given extra help to make sure that they had enough to eat and drink. People had access to a range of healthcare professionals when they required specialist help. However, when assessments were made of people's capacity to make decisions for themselves these were not decision specific and were generic.

Staff understood people's needs, wishes and preferences and they had been trained to provide effective and safe care which met people's individual needs. People were treated with kindness, compassion and respect.

People were able to see their friends and families when they wanted. There were no restrictions on when people could visit the service. Visitors were made welcome by the staff in the service. People and their relatives had been consulted about the care they wanted to be provided. Staff knew the people they supported and the choices they made about their care and people were supported to be involved in activities.

The manager had submitted their application to be registered with the commission. There were systems in place for handling and resolving complaints. People and their relatives knew how to raise a concern. The service was run in an open and inclusive way that encouraged staff to speak out if they had any concerns. The service had established links with local community groups which benefited people who lived in the service. Some quality checks had been completed however, areas which included medicines management and people's care plans had not been recently audited. This had not allowed the registered provider to address shortfalls in some of the care that people received.

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?

Requires improvement 

The service was not consistently safe.

Some of the checks needed to safely manage medicines had not been completed. People had not been helped to stay safe by managing risks to their wellbeing.

Staff knew how to recognise and report any concerns in order to keep people safe from harm.

There were sufficient numbers of suitably qualified staff on duty to keep people safe and meet their needs.

Background checks had been completed before new staff were employed

Is the service effective?

Requires improvement 

The service was not consistently effective.

People were not helped to make decisions for themselves. When this was not possible legal safeguards were not followed to ensure that decisions were made in people's best interests.

People were helped to eat and drink enough to stay well and people had received all the medical attention they needed.

Staff received on-going training so they had the skills and knowledge to provide effective care to people.

Is the service caring?

Good 

The service was caring.

Staff were kind and compassionate and treated people with dignity and respect.

People and their families were involved in their care and were asked about their preferences and choices.

Staff respected people's wishes and provided care and support in line with those wishes.

Is the service responsive?

Good 

The service was responsive.

People received personalised care and support which was responsive to their changing needs. However, quality checks had not identified shortfalls in one care plan we looked at.

People were supported to take part in social activities of their choice.

There was a system in place for resolving complaints.

Summary of findings

Is the service well-led?

The service was not consistently well-led.

Quality checks had not always identified problems that needed to be addressed.

The service did not have a registered manager in place, however, the manager had submitted their application to the commission.

People and their relatives had been asked for their opinions of the service so that their views could be taken into account.

Good teamwork was promoted and there was an open and inclusive approach to running the service.

Requires improvement

Holbeach and East Elloe Hospital Trust

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 visited the service on 24 June 2015 and the inspection was unannounced. The inspection team consisted of two inspectors.

Before the inspection the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The registered provider returned the PIR and we took this into account when we made judgements in this report.

During our inspection we spoke with five people who lived in the service and three visiting relatives. We spoke with the manager, two registered nurses, four members of care staff and two chefs.

We observed care and support in communal areas and looked at the care plans of five people and at a range of records related to the running of and the quality of the service. This included staff training information, staff duty rotas, meeting minutes and arrangements for managing complaints. We also looked at the quality assurance audits that the registered manager and the registered provider completed which monitored and assessed the quality of the service provided.

We reviewed other information that we held about the service such as notifications, which are events which happened in the service that the registered provider is required to tell us about, and information that had been sent to us by other agencies.

We asked the local authority, who commissioned services from the registered provider for information in order to get their view on the quality of care provided by the service. In addition, we contacted two health or social care professionals and asked them for their feedback on the care that people received at the service.

Requires improvement

Is the service safe?

Our findings

People had not been consistently safeguarded from the risks associated with the unsafe use of medicines. This was because staff had not always accurately recorded each occasion when a medicine should have been dispensed. We looked at 10 medicine administration records (MAR) and found some gaps. For example, one person's MAR indicated that a medicine had not been signed for on the 21 June 2015. Another MAR we looked at showed that three medicines had not been signed for on another date. This reduced the reassurance we could have that people had always received medicines in the right way.

We also found that there was inconsistency in the coding used when medicines had been omitted. For example, a code which indicated a person was asleep had been used for all the entries for 24 hours for one person. However, when we discussed this with the registered nurse they told us the person pretended to be asleep as they did not want to take their medicine. It then became clear that in essence the person was refusing their medicines. We also found that one person's topical cream had not been signed as administered. We were told the cream was not needed as the person's skin had healed, however, this was not recorded on the MAR chart. These shortfalls had not resulted in people experiencing actual harm. However, they increased the risk that people would not consistently benefit from using all of the medicines that a doctor said they needed to take.

There were no protocols in place to provide information on the reasons for the prescription of medicines which had been prescribed to be taken only when necessary, when they were required and any cautions for administration. As a result it was not clear when these medicines should be offered to the person and the reason for their use. We also noted that there were no dates to indicate when a liquid medicine had been opened. This meant that we could not be assured that the medicine was still in date and safe to use.

There were processes in place to ensure the timely ordering and supply of medicines. We found medicines were stored appropriately in locked cupboards and trolleys. Required temperature checks of storage areas to ensure medicines were stored in line with requirements were in place. Staff who administered medicines told us, and records confirmed, they received regular training about how to manage medicines safely.

We looked at five people's care plans and saw that possible risks to people's wellbeing had been identified in four of them. For example, the risk assessments described the help and support people needed if they had an increased risk of falls, were at risk of choking, had reduced mobility or were likely to develop a pressure ulcer. We saw that when a person had fallen, their care plan indicated that additional interventions had been put into place to reduce the risk of the person falling in the future. In addition, where bed rails were used to prevent a person rolling out of their bed, a risk assessment had been carried out to ensure they were appropriate for the person.

However, we found that no assessed risks had been documented for one person who had been admitted to the service on 27 May 2015. This meant that staff did not have access to current information which could assist them in taking appropriate action which would minimise risks to the person's well-being. This information was fed back to the manager on the day of the inspection. Action was taken to put the risk assessments in place immediately.

People said that they felt safe living at the service. One person said, "Yes I feel safe and well looked after here." Relatives were reassured that their family members were safe in the service. One relative said, "I am happy that [my relative] is safe here when I go home."

We asked staff to tell us how they maintained the safety of people who lived in the service. They were clear about whom they would report any concerns to and were confident that any allegations would be fully investigated by the manager. Staff said that where required they would escalate concerns to external bodies. This included the local authority safeguarding team, the police and the Care Quality Commission. Staff said that they had received appropriate training and there were up to date safeguarding policies and procedures in place to guide staff.

The manager demonstrated a good understanding of safeguarding vulnerable adults. The records we hold about the service showed that the manager had told us about any safeguarding incidents and had taken appropriate action to make sure people who used the service were protected.

Requires improvement

Is the service safe?

When accidents or near misses had occurred they had been analysed so that steps could be taken to help prevent them from happening again. For example, when a staff member had suffered a fall, action had been taken in line with the registered provider's health and safety policy. The incident had been reviewed at the health and safety meeting and action taken to prevent re-occurrence.

The registered provider had a business continuity plan in place. This included information about alternative accommodation and services in the event of an emergency such as severe weather conditions, staff shortages and loss of utility services. Personal emergency evacuation plans had been prepared for each person and these detailed what support the person would require in the event of needing to be evacuated from the building.

Staffing levels were kept under review by the manager and were adjusted based upon the needs of people. Staff said that staffing levels were appropriate and people we spoke with said there were always staff available to help them and there were enough staff to meet their needs. One person said, "I never have to ring my bell, the staff are always there. There is always someone here for me." Another person said, "The staff are attentive and kind. They are busy but I don't often wait." One relative said, "[My relative] has been here for 22 months and I have no complaints about the staffing levels. They get the care they need and don't need to wait."

There were other staff who supported the service on a day to day basis which included housekeeping, catering, administration and maintenance. Records showed that the number of staff on duty during the month preceding our inspection matched the level of staff cover which the registered provider said was necessary. We noted that call bells rang frequently but there were enough staff available to answer the bells and that people received the care they required in a timely way.

Five staff personnel files were checked to ensure that recruitment procedures were safe. Appropriate checks had been completed. Written application forms, two written references and evidence of the person's identity were obtained. References were followed up to verify their authenticity and two senior members of staff undertook all interviews. Disclosure and Barring Service (DBS) checks were carried out for all staff. These were police checks carried out to ensure that staff were not barred from working with vulnerable adults. These measures ensured that only suitable staff were employed by the service.

Requires improvement

Is the service effective?

Our findings

The manager and staff had an understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and had received training in the MCA. They knew what steps needed to be followed to protect people's best interests. In addition, they knew how to ensure that any restrictions placed on a person's liberty were lawful. We saw that they were aware of the need to take appropriate advice if someone who lived in the service appeared to be subject to a level of supervision and control that may amount to deprivation of their liberty. The service did not have anyone who was subject to a DoLS authorisation at the time of the inspection.

However, when we reviewed four people's care records we found that even though mental capacity assessments had been carried out when people lacked capacity to make some decisions for themselves, they were not decision specific. The decision which was made in the person's best interests was not recorded. For example, in one person's care plan we saw that bed rails were in use. There was no record of consent having been gained for their use. There was no mental capacity assessment or best interest decision undertaken to ascertain if the person lacked the capacity to make the decision for themselves.

People said that they were well supported and cared for by staff who had the knowledge and skills to carry out their role. One person said, "I am confident that the staff know what they are doing."

Staff completed induction training when they commenced employment. New employees were required to go through an induction which included training identified as necessary for the service and familiarisation with the registered provider's policies and procedures. There was also a period of working alongside more experienced staff until the worker felt confident to work alone. We saw that staff all held or were working towards a nationally recognised care qualification. The service had a training plan for the year.

The manager had an overview of staff training and kept an overall record to show what training each staff member had completed and when refresher training was due. We saw how action had been taken to ensure staff were trained on new pieces of equipment. For example, new pumps had been purchased which administered nutrition feeds and the manufacturer had provided training for staff so that they could safely use them. We saw that training had been provided to support staff in delivering end of life care to people in the service. The registered provider had established links with a local hospice and staff received training in end of life care and were also offered the opportunity to work a shift at the hospice.

Staff said that they were supported to do their role and that they received regular support, supervision and appraisal sessions from the management team. This gave staff the opportunity to discuss working practices and identify any training or support needs. We saw that the manager had recently introduced a learning theme for each staff member's supervision session. This included areas such as infection control and prevention, fire safety and tissue viability.

People told us they enjoyed the food they received in the service and received a healthy and nutritious diet. One person said, "I like the food. It's what I would eat at home." Another person said, "It's always nice and hot and well presented."

We observed people having lunch in one of the dining rooms in the service and noted that the meal time was relaxed and a social event in the day as people were encouraged to come to the dining room. However, people could dine in the privacy of their own bedroom if they wished to do so. People had ample portions of fresh, home cooked food, choices for each course and extra helpings when they asked for them. Cold drinks were freely available in all communal areas for people and staff made hot drinks for people at regular intervals and when requested .Their individual needs were catered for, independence was encouraged and staff monitored and stepped in with support and encouragement when needed. We saw that when necessary people received individual assistance from staff to eat their meal in comfort and that their privacy and dignity was maintained.

We spoke with the chef who explained how they worked to ensure that people received a full and varied diet. They knew which people required additional dietary support for needs such as swallowing problems, diabetes and weight loss and we saw how the lunch time meal was adapted to meet those needs. Although no-one in living in the service currently had specific cultural or religious dietary requirements, the chef was confident they could cater for those needs appropriately if required.

Requires improvement

Is the service effective?

People received good healthcare support. People's care plans contained evidence of the involvement of a wide range of professionals in the person's care and their access to on-going support. This included professionals such as their local doctor, dieticians, speech and language therapists and chiropodists. People and visitors said they were confident that a doctor or other health professional would be called if necessary. Visitors told us staff always kept them informed if their relative was unwell or a doctor had been called. One relative said, "If they [their relative] need to see someone they sort it out, no messing about."

Good

Is the service caring?

Our findings

People and relatives told us staff were kind and attentive to their needs. Staff interacted with people in a caring way, showing a genuine interest in their work and a desire to provide a good service to people. One person said, “The staff are all good. They work hard and I have no complaints.”

Relatives were also positive about the care people received. A relative said the care was, “Five star. I am well satisfied with everything.” Another relative said, “I think they are wonderful. They care about the people they look after. I would not have [my relative] anywhere else.”

Staff were positive about their work and told us they thought people were well cared for. One staff member said, “You treat people as you want to be treated. Yes, I would have my relative living here.”

There was a welcoming atmosphere within the service during our visit. Relatives said that they were made to feel welcome by staff and invited on a regular basis to planned events in the home and that often people stayed to have lunch with their loved one. We saw that there was a quiet room available where people could spend time with their relatives should they wish to. This room also allowed relatives to stay overnight should their loved one be unwell and they wished to be close by.

We saw staff supporting people in a patient and encouraging manner. For example, when staff helped people who needed assistance with eating this was conducted in a respectful and appropriate manner, sitting alongside the person and talking to them. Another staff member observed that a person was uncomfortable in their chair in the dining room and went to fetch a foot stool for them. Another member of staff supported one person to make their way to the dining table from their chair. They assisted the person in a kind, unhurried way and allowed them to walk at their own pace, encouraging and supporting them as they walked.

We saw that people were treated with respect and in a caring and kind way and staff referred to people by their preferred names. Staff were friendly, patient and discreet when supporting people. For example, people were assisted to leave communal areas discreetly and go to the toilet and other people were given gentle encouragement when they were walking with their mobility frames.

Staff recognised the importance of not intruding into people’s private space. Staff knocked on the doors to private areas before entering and ensured doors to bedrooms and toilets were closed when people were receiving personal care. For example, we were talking with a person during our inspection and the bedroom door was closed. A staff member arrived to assist the person to get out of their bed, knocked and waited before they entered. People’s bedrooms had comfortable chairs where people could sit and relax and enjoy their own company if they did not want to use the communal lounges. People could speak with relatives and meet with health and social care professionals in the privacy of their bedroom if they wanted to do so.

The manager was aware that local advocacy services were available to support people if they required assistance. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

Good

Is the service responsive?

Our findings

People who wished to move into the service had their needs assessed to help ensure the service was able to meet their wishes and expectations. We reviewed four people's care plans and found that they contained a summary of people's needs and abilities and provided key information for staff. Each registered nurse was responsible for updating care plans and ensuring they had been reviewed on a monthly basis. However, a person who had been admitted four weeks previously did not have a fully completed summary or care plan in place. This meant that there was a risk that staff would not be able to meet this persons needs consistently due a lack of current information. We spoke with the manager at the time of the inspection who agreed that this was not acceptable. They took immediate action and a care plan was put in place for this person. We asked how staff knew the level of support and care this person required and we were told that staff were given a comprehensive handover at the start of each shift. Staff were able to tell us about the care the person required.

Daily records of the care provided were completed and charts showed people at risk had had their position changed regularly and their food and fluid intake were being monitored. A relative said the care was, "Second to none." They said their relative was re-positioned regularly and all the support they needed was provided. People received care and support that was responsive to their needs because staff had a good knowledge of the people who lived at the service. Staff told us care plans were informative and gave them the guidance they needed to care for people. For example, one person's care plan described in detail how staff should assist the person with their personal care including what they were able to do for themselves. There was a record in some care plans of involvement of relatives in the review of the plans and their feedback.

People said that they were provided with a choice of meals that reflected their preferences. We noted how people were offered a range of alternative foods if they did not want what they had chosen. People could choose where they ate their meal, either in the dining room, in one of the lounge areas or in the privacy of their own bedroom if they wished to. People said they had been asked about their likes and dislikes and there was normally something on the menu they liked. We also saw how staff bought people jugs of drink and plates of food and allowed them to choose which they wanted. However, there were no pictorial aids available for people so they could relate the food to what they were eating and inform their choice.

People also had their own bedrooms and had been encouraged to bring in their own items to personalise them. We saw that people had bought in their own furniture, which included a favourite chair and cushions and that rooms were personalised with pictures and paintings. People had access to several lounge areas within the service and also a large garden with a seating area.

Staff talked with us about the need to respect people's individual needs and treat everyone equally. They recognised the need to adapt their communication to enable people to engage with them and gain their understanding. For example, we saw one staff member who observed that a person was becoming distressed at lunchtime. They quietly sat with the person and asked if they were ok and chatted with them. They talked about different things and this approach helped the person to calm down and enjoy their lunch.

People we spoke with were positive about the activities which were available for them in the service. One person said, "There are things that go on and I join in if I want to, but I like my own space." There were two care staff who had dedicated time each week to provide activities. The service also had a day centre within the building and people who lived in the service were encouraged to attend if they wished to. We noted on the day of our inspection that there was a planned quiz in the afternoon and this had been advertised and people invited to join.

Activities schedules were publicised in the service so that people knew what was available to them and therefore could make a choice. External entertainment was planned on a regular basis and people from local community groups visited the service on a weekly basis and undertook activities and provided a trolley shop service for people. People also had access to a mobile library which visited the service. People had been supported to celebrate their diversity by meeting their spiritual needs. We saw that individual arrangements had been made so that people could attend church services for their chosen denomination and a local member of the clergy visited the service on a monthly basis.

Good

Is the service responsive?

People were encouraged to raise any concerns or complaints that they had. The service had a complaints procedure which was available throughout the service. People we spoke with and their relatives told us they felt comfortable raising concern's if they were unhappy about any aspect of their care. Everyone said they were confident that any complaint would be taken seriously and fully investigated.

A system for recording and managing complaints and informal concerns was in place. There had been no formal written complaints since our last inspection of the service. Staff had access to 'problem forms' where they could document informal concerns raised and actions taken. This meant that the registered provider was able to investigate and record actions taken when informal concerns were raised.

Requires improvement

Is the service well-led?

Our findings

There were some quality assurance systems in place that monitored the quality of care and safety of care that people received. These checks included areas such as infection control, health and safety and tissue viability. However, we found that no formal audits had been completed of medicines management since February 2015. We also noted that no formal audits of people's care plans had taken place since December 2014. This meant that shortfalls we had noted earlier in this report around medicines management and care plans had not always been identified and quickly resolved. Although the lack of quality checks had not resulted in people experiencing actual harm, they increased the risk that people would not reliably receive all of the care they needed in a safe setting. We fed this finding back to the manager at the time of the inspection. Actions were taken immediately to assign lead roles to registered nurses who would oversee the audits of MAR and people's care plans.

The service had not had a registered manager in post since March 2015. A new manager was in post and they had commenced their application to become registered with the commission. The manager was available throughout the inspection and they had a good knowledge of people who lived in the service, their relatives and staff. We saw that the manager talked with people who used the service, their relatives and staff throughout the day. They knew about points of detail such as which members of staff were on duty on any particular day. This level of knowledge helped them to effectively oversee the service and provide leadership for staff. People said that they knew who the manager was and that they were helpful. The service had been without a deputy manager since March 2015 and this post was currently out to advert. The manager said that they were struggling to find a suitable candidate and that this had affected their workload as they were managing the whole service.

People and their relatives said that the service was well led and managed. One relative said they would often speak to the manager but they had never had a reason to complain. They said they talked to the manager and they were kept informed about their relative's condition.

Staff were provided with the leadership they needed to develop good team working practices and they were supported by the manager. Staff said that they were happy working at the service and felt supported with one staff member telling us, "You never have to pick your moment, they are very flexible. It's much better now they are in post." Another staff member said, "[The manager] has a nice connection with us all. They are a brilliant manager. If there is a problem they will talk to us about it and once it is sorted, there is no bad feeling."

Staff said that they had meetings to discuss matters and promote communication about what was going on in the service. We saw that there were regular department head meetings which included housekeeping and catering.

The service was governed by a council of members who oversaw the running of the service. The manager was responsible for the day to day running and reported back to the board on a monthly basis. The members visited the service on a regular basis and met with people who used the service, their relatives and staff members. Feedback was given to the manager on each occasion and also formally to the council at their monthly governance meetings. Action plans were in place to address any concerns raised. This showed that people were kept informed of important information about the service and given a chance to express their views. We noted from the minutes the positive feedback about the performance of the manager and how they had displayed a positive attitude towards their work and how this influenced the service.

The service had strong links with local schools in the area and had supported college students with work placements in the service. Due to the nature of the service there were strong links with the local community and the service was a beneficiary of donations following fundraising events.