MacIntyre Care

The Grove -4

Inspection report

4 The Grove
Westoning
Bedford
Bedfordshire
MK45 5LX

Tel: 01525718025
Website: www.macintyrecharity.org

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

4 The Grove is a care home for up to seven people with learning disabilities and/or autistic spectrum conditions. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection seven people were living at the home.

We checked to see if the care service had been developed and designed in line with the values that underpin 'Registering the Right Support' and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service should be able to live as ordinary a life as any citizen. The provider's values were strongly connected to these principles, which was reflected in the systems and processes used by the service. However, we found that the service did not always uphold these values in practice.

At our last inspection we rated the service as 'good'. At this inspection we rated the service as 'requires improvement'. This was because we found some areas of the service needed work to ensure the service provided consistently good quality support to people.

This unannounced inspection took place between 1 October 2018 and 16 November 2018.

There was a registered manager in 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.

People had detailed risk assessments in place to enable them, in most instances, to be as independent as possible whilst also remaining safe. However, there was insufficient evidence that, where restrictive measures had been in place for a long time, the continuing need for this was fully assessed.

There was information available to people about how to make a complaint, and information for staff on how to understand how people communicated this. However, this information was not used effectively to identify and act on complaints made by people who used the service.

Although people's support plans included information about end of life care and funeral plans, this information had not been reviewed or updated for many years.

Support Plans and risk assessments had not been rewritten for several years in some instances. Although they had been reviewed and amended by hand regularly, the reviews were not always robust..

Audits and provider quality monitoring visits had taken place but issues found at the inspection had not

been identified and acted on quickly to make improvements to the service.

Some of the people who lived at the service were unable to tell us about their experiences in detail, so we observed the support they received and their interactions with staff to help us understand.
People were clearly comfortable in the presence of staff. Staff had received training to enable them to recognise signs of abuse and they felt confident in how to report these types of concerns.

There were sufficient numbers of skilled staff on duty to support people to have their needs met safely. Effective recruitment processes were in place to ensure only suitable staff were employed

Medicines were managed safely and administered as prescribed and in a way that met people's individual preferences. The service was clean and people were protected from the risk of infection.

Staff understood and worked in line with the principles of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards. People were supported to have choice and to make decisions and staff supported them to be as independent as possible; the policies and systems in the service supported this practice.

Staff received an induction process and on-going training. They had completed training related to the specific needs of the people using the service to ensure that they were able to provide skilled care based on current good practice. They were also supported with regular supervisions and annual performance reviews (appraisals).

People were supported to have enough to eat and drink and were involved in making choices about meals.

People were supported to access a variety of health professionals when required, including opticians, doctors and specialist nurses to make sure that people received additional healthcare to meet their needs.

Staff knew the people who used the service well. People and relatives, where appropriate, were involved in the planning of their care and support. Where people were unable to be involved, the reason for this was recorded and care plans were written in people's best interests in consultation with people who knew them well.

People's privacy and dignity was maintained and staff treated them with kindness and respect. Care plans were written in a person-centred way and were responsive to people's needs. People were supported to follow their interests and join in activities.

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.

Risk Assessments were detailed and identified risks that were specific to individual people. However, where restrictive practices were in place, there was no evidence that the need for this had been regularly reviewed.

People were protected from abuse because staff understood the signs to look for and the process for reporting concerns.

People were protected from the risk of infection and medicines were managed safely.

There were enough staff deployed to keep people safe and effective staff recruitment reduced the risk of unsuitable staff being employed.

There was evidence that the provider learned from when things went wrong and made improvements to the service.

Is the service effective?

Good

The service was effective

The requirements of the Mental Capacity Act were met.

People had enough to eat and drink.

Staff received training to provide them with the skills and knowledge to support people who used the service.

Is the service caring?

Good

The service was caring.

People were supported by staff who knew each person well and had a kind, respectful approach.

People were involved in planning their care and support.

People's privacy and dignity were protected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Support plans were person centred but would have benefitted from full review.

People were encouraged and supported to find meaningful activities to be involved in.

End of life plans had not been recently updated.

Complaints from people using the service had not been managed or recorded sufficiently.

People were encouraged and supported to find meaningful activities to be involved in.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems to monitor the quality of the service did not identify some issues at the service that required improvement.

The provider promoted person centred care, but this was not consistently upheld at the service.

Staff completed surveys on behalf of people who used the service, but no independent support was provided to ensure people's views were accurately represented.

The service worked in partnership with other professionals to meet people's needs.

The Grove -4

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 comprehensive inspection took place between 1 October and 16 November and was unannounced. It was carried out by two inspectors.

Prior to the inspection we looked at information we held about the service and used this information as part of our inspection planning. The information included notifications. Notifications are information on important events that happen in the service that the provider is required by law to notify us about.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our visit we observed how the staff interacted with people who lived at 4 The Grove. We met the people who lived there, and where they were not able to tell us about their experiences in detail, we observed the interactions between them and staff. We also spoke with the Registered Manager and two care staff. We looked at three people's care records as well as other records and systems relating to the management of the service. These included systems relating to the management of medicines, meeting minutes and audits that had been carried out to check the quality of the service being provided.

After the inspection we contacted relatives of people who used the service to seek their views about the care provided to their family member.

Requires Improvement

Is the service safe?

Our findings

There were individualised risk assessments in place to enable people to be as independent as possible whilst maintaining their safety. They included assessments in relation to issues such as; going out in the community, finance, medicines, specific medical conditions, and participating in specific hobbies. The risk assessments and associated guidelines were detailed and updated with handwritten amendments made when changes to the person's needs were identified. However, over time, this can become confusing and lead to errors being made. A full review of these documents had not been completed for several years in some instances. For example, the guidelines to support a person to manage their behaviour was last fully reviewed in 2012. The registered manager told us that work to fully update all risk assessments and support plans was planned and would be completed as a priority.

The kitchen at 4 the Grove was locked at all times that staff were not present, and all drawers and cupboards in the kitchen, apart from the fridge were also locked. The registered manager confirmed this had been the case since the service had moved to the current location. They showed us a risk assessment that identified people were at risk from choking through eating certain foods and at risk of injury from knives and other kitchen equipment.

The registered manager told us that they had never known whether a specific incident had led to the practice of restricting access to the kitchen. They confirmed that they knew of no recent incidents that had taken place indicating this practice was still necessary. There was no record of how this decision was reached or continuously and meaningfully reviewed to ensure it was still necessary and the least restrictive action to protect people from potential risk.

This practice restricted all of the people who used the service, whether or not there was a current risk to them individually. While Deprivation of Liberty Authorisations (DoLS) were in place for people using the service, and these made reference to doors being locked for people's safety, there was insufficient evidence of continual review of this risk. This put people at risk because there was no evidence to support that the measures in place were continuously reviewed to ensure they were the least restrictive option.

We discussed our concerns about this with the registered manager. They acknowledged that the kitchen had always been locked and they had never questioned whether it was the only way to manage the potential risks to individuals who used the service. They demonstrated that they were open to reassessing this and looking at less restrictive options that may enable people to have access to the kitchen whilst managing risks. They suggested some ideas about how they might approach this. For example, by finding alternative places to store dangerous foods or equipment, and having the kitchen and some food cupboards unlocked.

All the people using the service needed full support to take their medicines and we saw care plans were in place to support staff to know how to do this. One person's records showed that medicine no longer prescribed was still a part of their support plan. In one area this medicine was crossed out but further down the page instructions to administer it were still included in the plan. This could be confusing for staff,

although the risk of this medicine being administered was removed as it had been returned to the pharmacy when discontinued. We looked at the Medicines Administration Records (MAR) for two people who used the service and these were completed correctly with no unexplained gaps.

Regular audits of medicines management were undertaken to ensure the providers medicines policy and processes were followed and that errors in administration and stock management were identified quickly should they occur.

Where people were unable to tell us if they felt safe we observed their interactions with staff to help us understand. We saw that people appeared comfortable and at ease in the presence of staff, and this led us to believe that they did feel safe. People's relatives were confident that their loved one was safe. One relative said, "They keep [person] safe, especially when going out with road awareness. If anything changes they immediately check it out."

Staff had received safeguarding training and were able to tell us about different types of abuse and how they would report any concerns they had. One member of staff said, "It's more about protecting the gentlemen we support; of making sure no harm comes to them so that they are not abused." They told us they had confidence that, if they reported concerns, the registered manager and the provider would take appropriate action to keep people safe from harm. Another member of staff said they had, "No concerns raising any issues and I feel that people are safe." There was information displayed about how to report safeguarding both within the provider's organisation and to external bodies such as the local authority and the Care Quality Commission.

There were sufficient numbers of appropriately skilled staff on duty to support people safely. Although there were some vacant permanent posts at the time of our inspection these were being recruited to. In the meantime, these vacant posts were being covered by the provider's own relief staff and agency staff most of whom knew the people living at the service having worked with them for some time.

Staff had been recruited using robust procedures and all necessary checks, such as references from the previous employer and Disclosure and Barring Services (DBS) checks were completed prior to the member of staff starting work.

Relatives told us the service was always clean, warm and inviting. People were protected from the risk of infection because staff followed current guidance on good practice in relation to infection prevention and control. We saw there were plenty of gloves and aprons and other infection prevention equipment and staff were seen to use these appropriately to minimise the risk of cross contamination. Colour coded mops and buckets and chopping boards were in place and we observed staff changing aprons and gloves before moving onto another activity. People were supported by staff to keep their bedrooms clean and we saw that they were involved in cleaning other parts of their home with varying degrees of support.

Records showed that the service had carried out all the relevant health and safety checks such as gas safety, electrics and fire systems. All water safety and temperature checks were carried out to monitor and reduce the risks of Legionella and of people being injured by hot water.

We saw that incidents and accidents were reported and investigated appropriately. Action plans were put in place by the management team to reduce the risk of similar incidents happening in the future. The provider had a system in place to support managers to analyse incidents and to identify trends and patterns and causes of incidents. This showed that that lessons were learned when things went wrong and improvements were made to the care people received as a result.

Good

Is the service effective?

Our findings

People's needs had been assessed prior to coming to live at the service. The provider's systems and processes were designed to ensure their care and support was delivered in line with current standards and evidence-based guidance, such as 'Registering the Right Support'. 'Registering the Right Support' values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service should be able to live as ordinary a life as any citizen. Care and Support was reviewed and updated as people's needs changed, and appropriate referrals to external health and social care services were made as necessary to ensure people's needs were met effectively.

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. Staff demonstrated an awareness of their responsibilities under the Mental Capacity Act and care records reflected the level of capacity peopled had in relation to various specific aspects of their care. Where people lacked capacity, decisions were made on their behalf in their best interests. We saw that staff took time to support people to make decisions and used communication aids, such as pictures, and objects of reference to support them to understand the decision they were being asked to make.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We saw from records that DoLS authorisations had been applied for as appropriate.

People's relatives told us that staff had the skills and knowledge of people to support them well. One relative said, "It takes a long time to get to know [name] but staff make sure that they know what person likes." Staff told us they received training that supported them to do their job well and our observations and review of records supported this.

Training records showed that staff undertook training related to the specific needs of people using the service such as epilepsy, positive behaviour management, and dementia awareness. This was in addition to training such as safeguarding people from abuse, moving and handling people, first aid, food hygiene, fire safety and health and safety.

Staff told us they received regular one to one supervisions and an annual appraisal. They confirmed that they were supported to develop within their role and that there were opportunities to complete qualifications to support their career progression.

People were supported to have enough to eat and drink and to make choices about their meals. Relatives confirmed that the quality of food provided to people was good. One relative said, "They know what [my relative] likes and dislikes and they are very flexible with the meals."

Staff told us that people decided what they wanted to eat each week and a menu was planned from this. People were supported to be actively involved in this process through a range of communication aids, such as pictures and objects of reference to enable them to understand the choices they were being asked to make. Each person made a choice of main meal and this was used to create a seven day menu. Staff told us that if people did not like a meal on any given day, they could select and were supported to have an alternative. We saw that a picture of the meal planned for that evening was displayed in the dining room.

People were supported to access additional healthcare when required. Within care records we saw that people had been referred to external professionals in a timely manner and staff had accompanied them to a variety of appointments, including dentists, GPs and specialist outpatient clinics. Each person had detailed health action plans that identified their health needs and how these were to be met.

The premises was accessible and suitable to people's needs. Corridors and rooms were wide enough for wheelchairs and hoists if required and there was level access to a garden area. The communal areas of the service were pleasantly decorated and comfortably furnished. People's bedrooms were personalised to their tastes.

Good

Is the service caring?

Our findings

Relatives told us that the staff were caring and one described them as, "Excellent." Another relative said, "Staff are great; [my relative] has always been treated kindly by them." People were unable to tell us about their experiences of the service, so we observed the support they received and the engagement between them and staff to help us understand.

Staff supported people in a calm and kind manner, which showed respect towards them and it was clear that people felt at ease in their company. There was a homely atmosphere and people appeared to be relaxed and secure in their home environment. A relative said, "It is totally [my relative's] home. [They] love going back after visiting the family home."

Staff communicated well with people, and clearly understood how each person needed to be supported to make decisions. They used a variety of methods to support communication, such as signs and gestures, pictures, objects of references, short simple questions, options (would you like this or this?). They took time and communicated at a pace that supported people to make choices as much as possible.

The registered manager told us that some families were involved in their loved one's care and support but that an advocacy service was available for anyone who may need it. A relative told us that the service had contacted an advocate to visit their relative once a month. Other relatives confirmed they felt involved and were able to give their views about their loved ones care.

We observed people being treated with privacy, dignity and respect. Staff knocked on people's bedroom doors and waited to be invited in. Staff involved people in conversations rather than talking to each other. Staff told us that they supported people with personal care in a discreet manner, making sure their privacy was maintained, and they were as covered as possible at all times.

Staff understood their role and promoted people's independence. Where people needed assistance, staff offered it in a natural and low key manner. For example, we saw one person was supported to make a drink; staff were on hand to support but stood back to enable the person to do as much as they were able to do independently.

Staff supported people to maintain relationships with friends and family where this was important to them. One relative told us, "They support [my relative] to come and see us as it is difficult for us to get to the service. This is important to [my relative]."

Requires Improvement

Is the service responsive?

Our findings

The provider had a complaints policy and processes in place to support people to make complaints. Within people's support plans there was detailed information about how each individual communicated complaints, which included changes in body language, mood and behaviours that may show the person was dissatisfied. However, we saw no evidence that the information in support plans had been used to understand when people were making a complaint. Complaints made by people in the ways described were not recorded in the formal complaints log. We discussed this with the registered manager, who acknowledged that this was a missed opportunity to make improvements to the service that they would take action to address.

Within people's care records was brief information regarding the person's wishes for their end of life care and funeral wishes. However, this information was more than 10 years old in some instances and people's needs and preferences may have changed in this time. The provider had introduced a new end of life support plan document which was very detailed and in accessible format. The registered manager told us that they were aware this part of people's support plan needed updating and that they would address this as a priority.

Records showed that people had been involved as much as possible in planning their support. Where people were not able to be involved in this process the reasons for this was clearly recorded, particularly where a person lacked the capacity to understand their support plan. In these circumstances it was recorded that the support plan had been written in their best interests. Relatives confirmed they were involved in this process.

Support plans were very detailed and reflected people's needs and preferences. Each aspect of support included guidance about what the person was able to do for themselves and what degree of support they required. Where people had plans in relation to managing behaviour that may have a negative impact on the person or others, they were written in a respectful and positive way. They detailed triggers and signs of escalation to support staff to reduce the chance of this behaviour occurring, and explained why the person may be communicating their needs in this way.

Although the support plans were written in a person - centred way, we noted that they had not been fully rewritten in some cases for several years and changes made were handwritten. Although regular reviews had taken place, these were not always robust. For example, the risks related to access to the kitchen had not been effectively reviewed since people moved into the premises and the current level of risk was not clear.

People were supported to follow their interests. A relative said, "My relative goes out a lot. They do horse riding, the allotment and helping in the kitchen. Horse riding is very important to [them] and it is great that they do this at the service." Another relative said, "[My relative] loves to walk and gets to do this all of the time." On the first day of the inspection, some people who used the service returned from a holiday they had been on, supported by staff.

Most people went to a day service during the week where they participated in activities such as horse riding, exploring the countryside and cooking. Most people had one day a week at home where they participated in tasks such as laundry and cleaning their room, but also had support to go out to places they enjoyed. The service was flexible about this and one person who did not want a day off went to the day service every week day. Their relative told us, "They tried to give [my relative] a day off from the day centre but it did not work, so they went straight back."

Requires Improvement

Is the service well-led?

Our findings

The provider showed a strong awareness of current guidance in relation to good practice in services for people with learning disabilities. The recent paper "Registering the Right support" is clear that the values that underpin a good service are choice, independence and inclusion; that people with learning disabilities and autism have the same rights to an ordinary life as all citizens. Although the provider promoted a person-centred culture, and systems were available to support and encourage this, the registered manager had not ensured this was consistently followed in practice in some aspects of the service.

Restricting access to the kitchen for all people who lived at the service without regular reassessment of the risks did not support a person centred culture at the service. Whilst this measure had successfully reduced the risk of people coming to harm, it had also restricted access to part of their home and their free access to food. This had continued for many years without robust checks being made to ensure it was necessary in all instances, and the least restrictive way to manage any identified risk.

People were supported to provide feedback on the service through a number of means including surveys and care reviews. However, the surveys we looked at were completed by staff members on behalf of the person and there was no sense that people had been meaningfully involved in this process. The registered manager was also unable to show us how the results from these surveys were analysed in order to improve the service. However, after the inspection the provider sent us an analysis document and an action plan which demonstrated that this information had been used to make improvements to the service. The registered manager said they would consider ways to support people to share their views that would provide more meaningful information to support improvements to the service.

Staff we spoke with were clear about their role and responsibilities and had a good theoretical understanding of the provider's values, talking with enthusiasm about their role in supporting people to take control of their lives. In practice, however, some opportunities to support people in this way were missed. For example, the providers support planning processes encouraged staff to have clear information about how people communicated their needs. Although the information was recorded, in practice, staff did not make use of this information in a way that empowered people, such as, information about how people communicated a complaint.

Some records relating to people's support, such as support plans, risk assessments and guidelines had not been fully rewritten for many years, and where changes had taken place, these had been handwritten. Although the content of the records were individualised and person centred, there was little evidence to show how the service had a positive impact on people over time, because it looked as if little had changed for people in many years. The lack of full review of people's support needs can lead to people being at risk of receiving unsafe or inappropriate care because information is not analysed to ensure it is still relevant. The locked kitchen door is an example of how practice can become stuck if not regularly challenged. The impact of this on people is that they do not have access to opportunities and personal achievements that they might have if services regularly analyse and challenge the support they provide.

The provider had systems in place to assess and monitor the quality of the support provided. A number of quality audits were carried out on a regular basis to assess the quality of the service and to support continuous improvement. There were regular visits made by the provider's regional managers to check on the quality of the service and action was taken to make improvements when issues were identified. However, we found that these monitoring checks were not always robust enough, and issues such as reviewing restrictive practices and the maintenance and updating of support plans and risk assessments had not been identified or acted on.

Relatives told us that communication from the service was good. They said, "The service is very good at keeping in touch. We always get minutes of reviews." They felt the registered manager was approachable and responsive. One relative said, "I can always phone the manager- any queries or questions I go to her- very approachable." Another relative said, "The manager is very kind and always reduces my anxiety."

Staff meetings took place on a regular basis and staff told us they had the opportunity to contribute to discussions and to share their views about the service and how improvements could be made. Staff were positive about the support they received from the management team and the provider. All the staff we spoke with told us the management team were approachable and they were confident that they would listen to any concerns they raised and take appropriate action.

The registered manager told us, and records confirmed, that the home worked in partnership with other key agencies and organisations such as the local authority, hospitals and other health professionals to ensure the provision of joined-up care.