Zebra Care Homes Limited

West Hill Place

Inspection report

12 Burrows Close
Woburn Sands
Milton Keynes
Buckinghamshire
MK17 8SN
Tel: 01908 584319

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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

We carried out this inspection on 16 February 2015 and it was unannounced.

West Hill Place provides accommodation and support for up to five people who have a learning disability or autistic spectrum condition. At the time of this inspection, there were five people living at the home.

The service has a registered manager. 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 were safe and the provider had guidance to enable the staff to safeguard people.

People's medicines were not always managed safely.

Summary of findings

People were supported to access other health and social care services to maintain their health and well-being. They were given a choice of food and drinks and where possible, supported to prepare their own meals.

People were supported to pursue their interests and hobbies and to maintain close relationships with their family members.

Information was available to people in a format they could understand and had access to an advocacy service.

There were sufficient staff to support people at all times and there were robust recruitment processes in place.

The staff did not receive effective training so that they supported people well and safely.

The staff understood and complied with the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards. They were caring and respected people's privacy and dignity.

The provider had a formal system for handling complaints. They encouraged people to contribute to the development of the service. However, their quality monitoring processes were not always used effectively to drive improvements.

We identified some breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in respect of how medicines were being managed, and ineffective staff training and quality monitoring processes. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

There was sufficient staff to meet people's individual needs safely.

There was guidance for the staff to safeguard people from the risk of harm.

People's medicines were not always managed safely.

Requires Improvement

Is the service effective?
The service was not always effective.

The staff understood their role in relation to the requirements of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards.

People were not always supported by the staff that had effective training and the necessary skills to meet their individual needs.

People were supported to have sufficient food and drink, and to access other health and social care services when required.

Requires Improvement

Is the service caring?
The service was caring.

Staff interaction with people was caring.

People's privacy and dignity were protected.

Good

Is the service responsive?
The service was responsive.

People were involved in assessing their support needs and staff respected their choices.

People were supported to pursue their hobbies and interests.

Information about the provider's complaints procedure was available in a format people could understand.

Good

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

There was a registered manager who provided stable leadership.

People who used the service and their relatives were enabled to routinely share their experiences of the service.

The provider's quality monitoring processes were not always used effectively to drive improvements

Requires Improvement

West Hill Place

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.

The inspection took place on 16 February 2015 and was unannounced. It was carried out by one inspector and an expert by experience whose experience is in supporting a person with a learning disability. 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 information we held about the service and this included a review of the notifications they had sent us. A notification is information about important events which the provider is required to send us by law.

We spoke with all five people who used the service, two staff members and the manager. We observed how care was provided and reviewed the care records and risk assessments for three people who lived at the home. We reviewed how medicines and complaints were managed. We looked at the recruitment and supervision records for two staff members, and training for all the staff employed by the service. We also reviewed information on how the quality of the service was monitored and managed.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed safely. We reviewed everyone's medicines and Medicine Administration Records (MAR) and we found that for two people, medicines were not always administered in accordance with the pharmacist's instructions. Staff did not follow the clearly labelled date order when they administered medicines to one person and this increased the risk of confusion and errors. For example, on 16 February 2015, we noted medicines in a dosette box dated 24 February 2015 had already been administered, the dosette boxes dated 3 February 2015 and 10 February 2015 were still intact, and we were unable to locate the dosette box for 17 February 2015. Our calculations also showed that there was excess medicine that had not been administered to the person. The manager told us that this was because the person did not take their medicines with them when they visited their family members. The manager's understanding was that the person's family kept some medicines for them. However, they were unable to demonstrate how they assured themselves that the person was taking the correct medicine while away from the home.

There was no signature on one person's MAR on 26 January 2015, and we were unable to check if the medicines had been given as there was no system for monitoring the stock levels of liquid medicines. There was also no signature to show that a person had their prescribed cream on 28 January 2015. We also found that a medicine prescribed by the GP and labelled by the pharmacist to be given in the morning was being given to the person in the evening without any explanation for this. The manager said that it had always been given in the evening, but appropriate action had not been taken to ask the GP to review the prescription. A medicines audit completed by a care staff on 3 February 2015 did not identify any of these issues. We discussed our concerns with the manager and they took immediate action to rectify the issues we highlighted. They also said that they would put systems in place so that they made sustained improvements.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt safe and they had positive relationships with the staff that supported them. Of the staff, one person said, "They are good to me." The provider had an up to date safeguarding policy, the staff had received appropriate safeguarding training and knew how to keep people safe. Although the manager had put plans in place to reduce the risk of further incidents, we noted that they had not reported to us two incidents of concern that had occurred between two people who used the service. On this occasion, they had not followed the reporting guidance necessary to keep people safe, but they assured us that they would do so promptly in the future.

The care records showed that care and support was planned and delivered in a way that ensured people's safety and welfare. There were personalised risk assessments for each person. Each assessment identified the person at risk, the systems in place to minimise the risk and the steps staff should take should an incident occur. We saw that where people demonstrated behaviour that had a negative impact on others or put others at risk, the assessment included information on what might trigger such behaviour, and steps that staff should take to defuse the situation and keep everyone safe. Risk assessments were reviewed regularly so that the level of risk to people was still appropriate for them.

A record was kept of all accidents and incidents and where required, people's care plans and risk assessments were updated to reduce the risk of reoccurrence. Also, a range of environmental audits had been completed so that people were cared for in a safe environment. Any issues identified as posing a risk had been rectified promptly. For example, an unsteady area of the stairs was sorted quickly to minimise the risk of injury to people who used the service and the staff. However, one person's bedroom door could be opened using another person's key. Despite the manager telling us that this had been resolved by changing the lock, we noted that this was reported as still being a problem the day before the inspection. The manager said that they will recheck and sort this, so that the person's personal property was secure.

There was enough staff on duty to support people in accordance with their care plans. The manager told us that people were always supported by a minimum of two staff and there was evidence of this in the rotas. Some of the people required additional support when in the community and were accompanied by enough staff during these activities. On the day of our inspection, two care staff, an activities coordinator and the manager were available to provide the support people needed.

Requires Improvement

Is the service safe?

We looked at the recruitment files for two staff and we found that there were robust recruitment procedures in place. Relevant checks had been completed before the staff started work to ensure that they were suitable for the role to which they had been appointed. These included obtaining references from previous employers, reviewing the applicant's previous care experience, and Disclosure and Barring Service (DBS) reports. DBS helps employers make safer recruitment decisions and prevents unsuitable people from being employed.

Requires Improvement

Is the service effective?

Our findings

People knew the staff well, as most had been supporting them for a number of years. They said that the staff knew their needs and supported them well. Records showed that the staff had received supervision, support through team meetings and relevant training, and this was up to date. However, we found the training was not always effective in enabling the staff to acquire appropriate skills and knowledge to support people safely and effectively. For example, all the staff that administered medicines had been trained, but they had failed to follow clear prescribing and medicine administration guidance. We also did not see evidence that their competence had been assessed. A new staff member had not always followed guidance when supporting a person whose behaviours may challenge others because we observed them discussing the person's behaviour with others. This inconsistency could have led to the person's behaviour worsening. However, the manager showed us evidence that they had already been supporting the staff member regularly so that they fully understood the importance of following the guidance in the person's care plans.

The manager told us that they delivered most of the staff training and they sourced external trainers for other training such as, 'First Aid'. The manager attended some of the training provided by the local authority. We noted that planned safeguarding training on the day of our inspection had been cancelled and they told us that they will attend on the next available date. A training file contained the information the manager used to train the staff. This had been put together over a number of years and the manager could not assure us that this information was still up to date. This posed a risk that the staff did not always have up to date information about trends and changes in the social care sector.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Six months prior to the inspection, we had received concerning information that people did not always have enough and nutritious food. The information stated that the fridge, freezer and food cupboards were frequently empty. On arrival to the home, we checked these areas and found that they were appropriately stocked with a variety of food. It was the home's designated shopping day and one care staff and the activities coordinator accompanied three people to go out and do the weekly food shopping.

Although there were planned menus presented in pictorial formats so that people could understand what was on the menu, people were able to choose alternative food that they wanted to eat on a daily basis. People told us that the food was generally good and they enjoyed it. Some also helped to prepare the meals.

People were provided with opportunities to be involved in the planning of their care and to give consent to the care provided. We observed that the staff asked for people's consent prior to providing any support and most people were able to tell the staff how they wanted to be supported. One person with limited verbal communication skills also used gestures to communicate their needs. The staff had received training on the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). There was evidence that where a person did not have capacity to make decisions about some aspects of their care, mental capacity assessments had been completed and decisions made to provide care in the person's best interest. We also saw that where necessary, DoLS applications had been made to the local authority and the manager was awaiting a decision for a referral made on 9 February 2015.

Staff told us that they respected people's decisions about their daily care and support needs, such as the time they got up, what they ate or wore or how they wanted to spend their time. One staff member told us that people were given opportunities and support to decide what they wanted to eat and the activities they wanted to take part in.

Records showed that people were supported to maintain their health and well-being. Staff told us that they made appointments for people to attend a variety of healthcare services, such as GPs, dentists and opticians, and they always arranged for a member of staff to accompany a person to their appointment. People's care plans identified any health issues that may require particular vigilance by staff to maintain the person's health and well-being. One person was at particular risk of epileptic seizures and their care records highlighted the need for staff to be vigilant,

Requires Improvement

Is the service effective?

although this was controlled with medicines and the person had last had a seizure in 2012. The management of their condition was also regularly monitored at an outpatient clinic.

Good

Is the service caring?

Our findings

People told us that the staff were kind and caring. One person said, “They are all good, I like them.” The results of the satisfaction survey completed in October 2014 showed that everyone was happy about the staff that supported them. We observed that the staff interacted with people in a caring way. They always spoke with people as they passed them and asked if they were alright or wanted anything, and there was a homely atmosphere. We saw that the staff were sitting in the lounge with people and talking with them at various times during the day. Communication was mainly focused on what people wanted to talk about or do, but sometimes the staff chatted with each other which increased the risk of people feeling excluded. However, we observed that this was only for short periods and therefore did not have any negative impact on people who used the service.

People’s care records included an individual profile called ‘About Me’, which provided information about people’s preferences, their life histories and things that were important to them. This had provided the information the staff needed to know how people wished to be supported. People told us that they had been given information they required and could always ask the staff or the manager if they were not sure of anything. Information was provided to people in an easy read format so that they could understand it. Most of the people’s relatives had some involvement in their care and provided additional support if this was required. Some people also had social workers who were involved in the commissioning and review of their care, and information about an independent advocacy service was available so that people had the necessary details they required if they wanted to contact this service.

Staff told us that they supported people in a way that maintained their privacy and protected their dignity and this was confirmed by people we spoke with. We saw that the staff knocked on people’s bedroom doors and waited to be invited in before entering the room. The provider’s ‘code of practice’ also required that the staff maintained people’s confidentiality by ensuring that people’s personal information was always protected and that they never discussed people’s care outside of the service or with agencies that were not directly involved in people’s care.

People had been supported to maintain their independence as much as possible. One person had been supported to use the bus independently to visit neighbouring towns following the service moving to the current house. They said that they liked that they could now easily get out and about because of easier access to public transport. The staff told us that the move to the new house had been completed with ease. People told us that they liked the new house and they chose how they wanted to decorate their bedrooms and the communal areas of the home. One person said, “This house is better.” They told us that this was because the big hill was too steep to climb at the previous house and got them tired when they were walking to the shops.

Good

Is the service responsive?

Our findings

People told us that they received care that met their individual needs. People's needs had been assessed and care plans were in place so that people were supported effectively. They also said that their preferences, wishes and choices had been taken into account in the planning of their care and support, and this was evident in the care plans we looked at. Where necessary, people's relatives also contributed to the planning and review of the care. We saw evidence of reviews in the care records and the staff also confirmed that this happened regularly or when people's needs changed.

Although staff supported people promptly when they required it, we found their interruptions when we were speaking to people, did not always allow them the opportunity to tell us their experience of the service in their own words. Most people were able to speak with us this without staff support, and this was only necessary on one occasion when a person was becoming distressed because we were unable to understand what they were saying when they were telling us about their family. However, they quickly settled with staff support.

People told us that they were frequently supported to take part in activities they enjoyed. Some people attended a day centre in a local town. One person said they did cooking and dancing there. Another person had part-time work at a local bowling club and they told us that they also liked swimming, cinema trips and going to the park. The person who could go out using public transport unaccompanied told us that they visited the local town regularly, including to watch football matches at the local football club. They also supported a football team in London, but they did not visit this regularly as it was too expensive. They had a mobile phone they could use to contact the staff if they needed support while away from the home. They were also being supported to cook their own meals in preparation for them living in their own flat in the future. However, another person told us that they were not always safe around hot appliances and they did not trust that they could cook without ending up burning themselves.

People had varied interests and hobbies and their bedrooms had been decorated to reflect this. One person had a collection of train models and another had football memorabilia. People were accompanied by the staff on shopping trips using a car owned by the provider. It was evident that they had opportunities to take part in a variety of activities, including trips to places of interest and holidays at seaside locations. Some of the people visited their relatives regularly at weekends. The staff told us that any birthday celebrations for people were normally planned with their relatives. They told us of an occasion when one person had a party at their family's home and invited the rest of the people who used the service and the staff to attend.

People said that they could tell the staff, the manager or their family members if they were not happy about anything. People had been provided with information on how they could make a complaint in an easy read format. The contact details of other relevant agencies, including an independent advocacy service had also been included. People were happy with their care and did not feel the need to raise any concerns. Records showed that no complaints had been recorded in the last 12 months and the manager said that they would always manage any complaints in accordance with the provider's procedures.

Requires Improvement

Is the service well-led?

Our findings

The staff completed various audits to assess and monitor the quality of the care provided. This was done regularly, but there was a lack of managerial oversight. For example, audits of the Medicine Administration Records (MAR) had failed to identify gaps on the records and that medicines were not always administered in accordance with the prescriber's and the pharmacist's instructions.

There was a registered manager in post who was experienced, having managed the service for a number of years. However, they were unable to show us evidence that they regularly evaluated the records completed by the staff and had not checked if the staff remained competent to carry out their roles safely and effectively. They had also omitted to report two incidents that should have been reported to us. We reminded them of their duty to report to us any notifications as stipulated in the guidance available to all providers. There was also no evidence that the manager measured and reviewed the care provided against current guidance. However, the manager told us that they received regular updates about trends in social care as part of the provider's subscription to a care services association. They had a list of areas that they needed to check occasionally. However, they told us that there was no requirement for them to complete and send a monthly audit report to the provider. The manager told us that they analysed all the audits, but there were no records kept to reflect this. We found the manager had not always used the quality monitoring processes effectively to drive improvements.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People knew who the manager was and they told us that they liked him. One person said, "I like him, he makes me laugh." The manager was present throughout the inspection, although a conversation between two staff indicated that he was not always visible within the home. However, we observed that the culture of the service was open and person-centred. People were treated as individuals and enabled to express their individuality, particularly in the way they decorated their bedrooms and the hobbies and interests they pursued. People were supported to maintain links with the local community and one person told us that they enjoyed having a drink at a local pub.

There was evidence of staff meetings where relevant issues about people's care were discussed. Staff also used the communication book to record issues that needed to be communicated and acted on quickly. However, we found some of the content of these were not always professional and respectful about people who used the service. However, we saw that a staff member had quickly pointed this out. The manager told us that they would also address these issues with individual staff during supervision.

People were encouraged to contribute to the development of the service by way of regular opportunities to discuss issues with the staff and the completion of annual surveys. People did not want to have regular meetings, but as a small service, they were always able to discuss menu choices, activities and plans for holidays or concerns with the staff individually or in small groups. We saw the results of the annual survey completed in October 2014. The questionnaire was in an easy read format and the pictures used were chosen to specifically reflect each person's interests. For example, for one person's questionnaire, the provider had used pictures associated with 'Mr Bean' and for another person, 'Del Boy', both popular television characters. People's comments were mainly positive, but two people said that a bigger car was needed so that they could sit comfortably when most of them were in it. The manager told us that this was being reviewed by the provider.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Medicines were not always managed safely.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not effectively assess and monitor the quality of the service provided.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The staff did not receive effective training to enable them to carry out their roles safely and effectively.**