

Tracs Limited

Spinney Hill

Inspection report

56 Spinney Hill Road
Northampton
Northamptonshire
NN3 6DN

Date of inspection visit:
29 July 2016
02 August 2016

Date of publication:
07 September 2016

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

This inspection took place on 29 July and 02 August 2016 and was unannounced.

Spinney Hill provides accommodation and personal care for up to three people some of whom may have learning disabilities or a mental health diagnosis. There were three people living at the home during this inspection.

The service did not have a registered manager in place. There was an acting manager who had made an application with the Care Quality Commission to become the 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 did not always receive their medicines safely. People's prescribed medicines were not always administered to them. This constituted to a breach of the regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

People's capacity to consent to their care and support was not always assessed. Some people's individual plans of care showed that they were supported with restrictive care interventions however; their ability to consent to this care and support had not been assessed. This constituted to a breach of the regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

There were not effective systems in place to monitor and improve the quality of the service. Improvements to the service were not constantly identified and where improvements had been identified as being required these were not always made.

Quality assurance procedures were not implemented to ensure that people received the care and support that they required. This constituted to a breach of the regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Incidents and accidents were not always reported to the manager appropriately. This meant that any learning arising from incidents or accidents could not be implemented to prevent them from occurring again.

People felt safe. Staff were able to identify if people were at risk of harm and were confident in the steps that they would need to follow if they suspected that someone was being harmed.

There were effective recruitment processes in place so that people were supported by staff of a suitable character. Staffing numbers were sufficient to meet the needs of the people who used the service and staff received relevant induction and training. Staff were knowledgeable about their roles and responsibilities and had the skills, knowledge and experience required to support people with their care and support needs.

People had detailed individual plans of care that had been developed to guide staff in how to care for people. Staff were knowledgeable about people's care and support needs however did not always have access to people's most up to date plans of care. This meant that people were at risk of receiving inconsistent care and support.

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.

People could not be assured that their medicines were managed safely.

Accidents and incidents were not always recorded or escalated to the manager so that people's individual plans of care could be reviewed or learning from incidents implemented.

Staff were knowledgeable about how to manage the risks associated with people's care and support needs.

Requires Improvement ●

Is the service effective?

The service was not always effective.

People's capacity to consent to their care and support was not always considered.

People received care from care staff that had the training and acquired skills they needed to meet people's needs. However, staff did not always receive adequate formal supervision.

People were supported to have sufficient to eat and drink to maintain a balanced diet.

Requires Improvement ●

Is the service caring?

The service was not always caring.

People were not always involved in making decisions about their care and support.

People had developed positive caring relationships with staff.

People's privacy and dignity were respected.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Requires Improvement ●

Appropriate and timely action was not always taken to address people's complaints or dissatisfaction with the service provided.

Staff did not always have access to people's most up to date individual plans of care.

People's plans of care were not always followed meaning that people did not always receive consistent care and support.

Is the service well-led?

The service was not always well-led.

The provider had systems available for the manager to review and assess the quality of service; however these systems had not been effective in driving improvements in the service.

People's records were not always accurate and complete.

Staff knew how to question practice and system were in place to support staff to whistleblowing.

Requires Improvement 

Spinney Hill

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 29 July and 02 August 2016, was unannounced and was undertaken by one inspector.

Before the inspection, the provider completed a Provider Information Return [PIR]. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made judgements in this report. We also reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies. This included the local authority who commissioned services from the provider.

During our inspection we spoke to three people who used the service; we also spoke with seven members of staff including the manager, area manager and quality manager.

We spoke with people from the local authority who commission the service. We looked at records and charts relating to three people and three staff recruitment records. We looked at other information related to the running of and the quality of the service. This included quality assurance audits, training information for care staff, staff duty rotas, meeting minutes and arrangements for managing complaints.

Is the service safe?

Our findings

People could not be assured that their medicines were managed safely. People did not always receive the medicines that had been prescribed for them. Although most medicines were dispensed by the pharmacy in blister packs, some medicines had been dispensed by a pharmacy in its original packaging; these were not always administered as prescribed. We found four examples where people's medicines had changed and been dispensed in their original packaging but had not been administered to people for over two weeks. These medicines had not been recorded on people's Medication Administration Record (MAR) sheets when they were received meaning that staff had not administered them to people. Staff were not aware that people's prescribed medicines had changed and were unclear when asked what medicines they should be administering. We instructed staff to contact people's GP's to find out what medicines they were prescribed and to make a safeguarding alert to the local authority.

The failure to ensure the proper and safe management of medicines was a Breach of Regulation 12(1)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were knowledgeable about how to manage the risks associated with people's care and support needs. People had risk assessments in place that had been reviewed regularly to ensure that the information was still relevant. Staff we spoke to were knowledgeable about the risks to people and were able to describe how they followed people's individual plans of care to manage the risks to them. For example staff were able to describe why they provided one person with one to one support when accessing the community and what risks they were aware of when supporting this person.

Accidents and incidents were not always recorded or escalated to the manager so that people's individual plans of care could be reviewed or learning from incidents implemented. We saw one example of an incident whereby one person's daily records recorded them as hitting a member of staff. An incident report for this had not been completed and the manager was unaware that this incident had occurred. This meant that this person's plans of care could not be reviewed or any learning from this incident used to try and prevent future similar incidents occurring. We saw another example of an incident whereby staff had recorded in one person's daily notes that they had needed to use a physical intervention. This incident had not been reported to the manager so that the learning could be implemented to prevent similar incidents occurring in the future.

Staff understood their responsibilities to safeguard people and knew how to raise any concerns with the right person if they suspected or witnessed ill treatment or poor practice. One member of staff told us "I would report any concerns to my manager or another manager if they were not available. I also know how to contact the Local Authority." Staff had received training on protecting people from harm and records we saw confirmed this.

There were sufficient numbers of staff working to meet the needs of people living in the home and to provide safe care and support. One member of staff told us "There are enough staff working on shift. Staff from other homes can also work here which means we never run short of staff." Throughout the inspection

we observed that there were enough staff to meet people's needs in a timely manner. Staff had time to engage positively with people using the service and to provide a range of meaningful activities.

Safe recruitment processes were in place to protect people from the risks associated with the appointment of new staff. We saw that references had been obtained for staff prior to them working in the service as well as checks with the Disclosure Barring Service (DBS). The registered manager told us that she operated a thorough recruitment process and would only employ staff that she felt would be competent to work in the service.

Is the service effective?

Our findings

The Mental Capacity Act (MCA) 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the manager had made DoLS applications to the local authority for some people where they had been assessed as lacking capacity to be able to consent to their care. However, we found that one person was being deprived of their liberty and the manager had not sought the appropriate authorisations for this.

People's capacity to consent to their care and support was not always considered when planning and providing their care. Staff had received training in the Mental Capacity Act and they were able to demonstrate an understanding of the key principles of the act. However, systems were not effectively implemented to ensure that people's capacity to consent to their care and support was always sought.

Where people were subject to restrictions or were not free to leave the home unescorted due to concerns about their wellbeing, mental capacity assessments had not always been undertaken to establish whether they understood why these safeguards were in place. Care plans did not always include an assessment of people's capacity to consent to aspects of their care and support.. One person also had restrictions placed upon their access to the internet, their mobile phone and their laptop. We saw that at times this person was resistant to their care and support however, their capacity to consent to these plans of care had not been assessed and the provider could not show that they were working in this person's best interests. Another person had an audio monitor in their bedroom so that staff could monitor whether they might be having a seizure. We were advised that this had been agreed as being in their best interests, but there was no mental capacity assessment regarding this decision. There was also no evidence that these plans of care had been discussed or agreed with other professionals involved in planning the care and support of these people such as social workers or community nurses.

The failure to adequately assess people's ability to consent to their care and support constituted a Breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they could not recall having recent formal supervision meetings with their relevant senior member of staff. One member of staff told us "I've not had any supervision since I joined six months ago." Supervision is needed so staff can discuss their performance, development and training needs. We therefore checked to see what formal supervision staff had received. We found that staff had not always received appropriate supervision to ensure they provided people with effective care. The area manager told us that the acting manager for the service would be conducting staff supervisions for all staff and that this was an

objective that had been set for them.

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People told us that they had access to healthcare professionals when they needed to. Records were not maintained to show what healthcare professional's people had seen and any actions that staff were required to undertake. We saw that two people's prescribed medicines had recently been changed following a visit to their GP in July 2016 however, there were no records of this medical appointments having taken place. This meant that the actions arising from these appointments; which were to change the medicines that people were administered, were not completed. This is because the information was not recorded or shared with staff working within the service.

Staff received training that was relevant to their role and that equipped them with the skills and knowledge that they required to support people effectively. One member of staff told us "I have had a lot of training since I started. We have to do it and its very good here." Staff we spoke to told us how recent training was relevant and useful to their work. Records confirmed staff had received up to date training in relevant areas and staff had relevant skills and knowledge to support people's needs effectively. We saw that there was an annual programme of training provided that staff were required to complete.

New staff had a period of induction to enable them to develop confidence and support people in the home effectively. One member of staff told us "When I first started I read through care plans and spent time shadowing staff to observe what to do." New staff had access to training and support to equip them with the knowledge and skills that they needed to care for people. New staff also had a period of time whereby they worked alongside more experienced staff to observe them working.

People were able to choose what they wanted to eat for their meals and to help prepare them if they wanted to. One person told us "I help with the cooking here and we all sit down once a week and plan the menu; the food is good." People had a menu available within the dining room showing the planned meals for the week. People were also able to help purchase the food and drink for the service. People had access at any time to snack and drinks. Staff were aware of people's dietary needs and food intolerances and ensured that appropriate meals were provided.

Is the service caring?

Our findings

People's individual plans of care were not always discussed with them. This meant that people did not always have choice and control over how they were supported. One person told us "I have a care plan, it's kept upstairs and the staff follow it." We saw that the provider had implemented a system whereby people should have the opportunity to have monthly meetings with a member of staff to review their plans of care and decide if these were still reflective of their preferences. Records showed and staff confirmed that these meetings had not taken place consistently and that due to staff changes people did not always know who was responsible for reviewing their plans of care to provide feedback to.

The provider had also implemented a system of "house meetings" where people living in the home should have the opportunity to meet together with staff to plan activities, menus and provide feedback on the service that they were receiving. We saw that these meetings had not been taking place and could not find any evidence of a house meeting having taken place in 2016. This meant that people were unable to plan activities in advance and had to rely upon staff asking them what they wished to do on a day to day basis.

People had developed positive relationships with the staff supporting them. One person told us "The staff are brilliant; very helpful." People were supported by a team of staff that approached them in a kind and caring way. There was laughter in the house and staff were able to respond to people in a firm but kind way if required. It was clear from the interactions we observed that staff knew people well. We saw that staff were skilled in their interactions and were able to calm people when they became unsettled and distract them with items that interested them. Staff provided positive reassurance to people and were knowledgeable in deescalating potentially challenging situations.

People were able to choose what they did during the day on a daily basis and staff supported people to pursue their interests. One person told us "I have a pet rabbit in the garden that the staff help me look after." Another person told us "I am going on holiday soon [staff] will be booking it for me now that I've chosen." Staff asked people what they wanted to do in the day and we observed staff supporting people to access community activities of their choice.

People were encouraged to take on roles of responsibility within the home to increase their independence. One person told us "I look after the kitchen and put the shopping away, sometimes help to cook and sort the dishwasher out. It's good." We saw that this aided this person's sense of wellbeing.

The staff we spoke with understood how to protect people's privacy and dignity. We observed that doors were closed when people received personal care and that staff knocked on people's bedroom door before entering.

Is the service responsive?

Our findings

People told us that they knew how to complain. One person told us "I would tell the staff if I had a complaint." However, we saw that where people had informed staff that they wished to make a complaint that these were not always recorded or acted upon.

People's complaints were not always responded to. We reviewed the records relating to complaints that had been made about the service. Complaints had been recorded as being received however; these had not been formally responded to by the manager. One person living in the home had made a complaint which had been logged however, this complaint had not been investigated and no response had been provided to this person. This means that people could not be assured that their concerns or complaints would be responded to appropriately or used to improve the quality of the service. We reviewed the records relating to complaints with the regional manager who said that she would ensure that the complaints recorded were now investigated and that people received a formal response.

People had detailed individual plans of care that had been developed to guide staff in how to care for people. These gave an overview of people's life history, interests and care needs. These plans of care were stored within an office in the home. When we asked to view people's plans of care we found that they were disorganised and although people had plans of care that had been developed these were not stored together or easily accessible to staff. Some people did not have plans of care that had been printed and these were saved on a computer however, staff did not have access to this computer.

We spoke to staff who were knowledgeable about people's care and support needs. One member of staff who was new to the service told us "I know people well; I shadowed more experienced staff when I joined and they told me how to look after people." Staff told us that they had read people's individual plans of care however; the regional manager told us that a number of people living in the home had new plans of care in place. These new plans of care were not available to staff which meant they were unable to follow them. This meant that people were at risk of receiving inconsistent care and support.

We observed examples of people receiving inconsistent care and support. One person living in the home had a behavioural support plan in place that staff should redirect this person onto a new activity if they asked repetitive questions because it could identify that this person was becoming unsettled. We observed one member of staff ignore this person when they were asking them questions about the planned activities for that day seeking reassurance. We reported this to the regional manager who told us that she would discuss this person's plans of care with all staff to ensure that they supported this person consistently.

People were supported to follow their interests and pursue their hobbies. One person living in the home told us "I go to a club three days a week and the staff always take me." We observed one person asking to see a film at the cinema. Staff supported this person to plan a day when they could go to the cinema and said that they would take them.

Is the service well-led?

Our findings

There was not consistent or visible management or leadership within the service. One member of staff told us "I met the manager when I first started but she manages two homes so we have limited opportunity to see her." Another member of staff told us "Sometimes we are taken away from delivering care because we have to do admin work because of the lack of management." We met the acting manager who told us "I am working across two services; it is hard. There is only so much I can do." We found that staff had not received regular supervision and the lack of leadership and management had resulted in the providers systems and processes not being implemented consistently within the home. We found that systems to gather feedback from people using the service had not been implemented, complaints had not been responded to and that people's care planning documentation was disorganised and not readily accessible to staff.

The provider had a strong system of quality assurance audits in place that had identified a number of areas where improvements were required however; these improvements had not been implemented. The provider had monitored the progress of actions being completed however, had failed to assure themselves that when they were told actions had been achieved that they had in reality been completed. For example, the providers audit had highlighted the need for people living in the home to have their capacity to consent to their care and support assessed and DoLS authorisations requested. The provider had recorded that this had been completed however, we found that people living in the home had not had their capacity to consent to their care and support assessed. The provider had also highlighted the need for people's care planning documentation to be updated and reviewed. We found that people's care planning documentation had not consistently been updated and where it had been updated these updated plans of care were not available to staff to implement. The provider had recorded that this action had been completed by the manager.

We discussed this with both the regional manager and the quality manager for the provider. They acknowledged that there had been a failure to implement the improvements identified by quality audits. They told us that they would provide the home with additional support to implement improvements.

This inspection highlighted shortfalls in the service that had not been resolved by the monitoring systems in place. The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services was a breach of Regulation 17 (1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were knowledgeable about the systems in place and actions to take if they wished to raise concerns. We noted that the provider had a whistleblowing policy in place for staff to follow if they wanted to raise concerns. Staff told us they knew about the whistle blowing policy and how to access it. One member of staff said "There is a Whistleblowing policy with a telephone number I can call upstairs or I know I can telephone the Care Quality Commission." Policies and procedures to guide staff were in place and had been updated when required. We spoke with staff that were able to demonstrate a good understanding of policies which underpinned their job role such as safeguarding people, health and safety and confidentiality.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's ability to consent to their care and support was not always assessed.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not managed in a safe and proper manner. We found examples where people's medicines had been changed by a medical professional however, the new medicines prescribed had not been administered to people.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were not effective systems in place to monitor, assess and improve the quality of service provided.