Care Quality Commission

Holmleigh Care Homes Limited

Hunters Moon

Inspection report

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Ratings

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

Overall summary

This inspection took place on 12 June 2015 and was unannounced. We returned on 16 June 2015 to complete the inspection. Prior to the inspection we received information of concern relating to abuse of a person who lives at Hunters Moon.

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 and associated Regulations about how the service is run.

Hunters Moon is a care home which provides accommodation and personal care for up to seven adults with a learning disability and associated complex needs. Prior to our inspection, the Community Team for People with a Learning Disability had carried out an investigation into an allegation of abuse towards a person who lives at

Summary of findings

Hunters Moon. We found that staff did not come forward or whistleblow. People told us they felt safe when the staff involved were dismissed and no longer worked at the home.

During our inspection we spoke with two agency workers and found that they were not suitably skilled or experienced to be able to safely support people who live at Hunters Moon.

Permanent staff at Hunters Moon told us they received good training in order for them to do their job well.

Not all staff had received a supervision this year and no staff had received an appraisal within the last year. The registered manager told us they had fallen behind in them.

People liked the staff at Hunters Moon and families told us they were caring and kind. Staff treated people with respect and dignity and communicated with people in a way which empowered them to participate in making choices.

There were a range of activities which people could take part in and families said the staff supported their family member to visit them. Each person had a care plan in place which identified their preferences for the way they wished their care and support to be delivered. Risk assessments were used to identify what action needed to be taken to reduce potential risks which people may encounter as part of their daily living.

Applications had been approved where people's liberty was restricted and people and their families had been involved in making a best interest decision.

The registered manager did not submit a statutory notification to the CQC when the police became involved in the abuse case. The registered manager did not follow the disciplinary procedures in place to ensure that the conduct and behaviour of the two members of staff involved was monitored and responded to. When the abuse was substantiated, there was a delay in the registered manager reporting the staff concerned to the Disclosure and Barring service.

The culture within the home did not evidence an open and transparent culture where abuse was not tolerated and where staff felt able to raise concerns without fear of recrimination.

There was a complaints system in place and families told us they had no complaints. The policy was available to people in an easy to read and pictorial format.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

Ensure that providers found to be providing inadequate care significantly improve.

Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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 safe.

An investigation into abuse had been substantiated.

Agency staff did not have the appropriate skills and experience to support people safely.

People told us they now felt safe.

Inadequate

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

Not all staff had received a supervision during 2015.

Permanent staff at Hunters Moon were skilled and experienced in caring for the people they supported.

People told us they liked the food.

Requires improvement

Is the service caring?
The service was caring.

People told us they liked the staff.

Staff were kind and treated people with respect.

People were afforded privacy and dignity when staff offered personal care.

Good

Is the service responsive?
The service was responsive.

People and their families were involved in planning their care and support.

Families told us that Hunters Moon staff supported people to visit their family home.

There were opportunities to take part in activities if people wished to.

Good

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

Staff did not come forward to report abuse because the culture in the home did not promote this.

The registered manager did not follow disciplinary procedures as required.

Families thought the home was well led.

Inadequate

Hunters Moon

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 over two days, 12 and 16 June 2015 and was unannounced. The inspection was carried out by two inspectors.

We spoke with four of the seven people living at Hunters Moon. Where people were not able to verbalise their opinion about what it was like to live at Hunters Moon, we observed how staff supported people. We spoke with four relatives about their views on the quality of the care and support being provided. We also spoke with the registered manager, the deputy manager, two senior care workers, three care workers and two agency workers.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking with people, their relatives, looking at documents and records that related to people's support and care and the management of the service. We reviewed the care records of three people. We looked at staff records relating to supervision and appraisal. In addition, medicine administration records, information on notice boards, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices throughout the day.

Inadequate

Is the service safe?

Our findings

During this inspection, we followed up information of concern we had received from the Community Team for People with a Learning Disability. (CTPLD)

The CTPLD were involved in investigating a disclosure of abuse made by a person who lives at Hunters Moon. Following an investigation, it was substantiated that the person had been subject to psychological abuse, was degraded and had their personal property destroyed. The two members of staff found responsible for the abuse were dismissed.

All staff who work at Hunters Moon had received training in safeguarding people and in whistleblowing where they had concerns about the people in their care. The incidents of abuse were dated from mid-January to early May 2015. After the first incident, none of the staff raised an alert with the registered manager or with the local safeguarding agency, this allowed the abuse to continue. Staff told us they felt intimated by the staff involved which is why they did not come forward.

When an allegation of abuse was substantiated by the internal investigations carried out by the home and by the community team for people with a learning disability, there was a delay in making the referral onto the disclosure and barring service as required.

In April 2015 some staff raised concerns about the conduct of the two staff and how they were treating the individual concerned. Some of the concerns raised by staff were about the way the perpetrators spoke to the person. The registered manager had also witnessed this. The registered manager failed to ensure that whilst in their employment, the conduct and behaviour of the two members of staff was monitored and reviewed, and that the provider's disciplinary procedures were followed as required.

Due to staff leaving and changing their hours, the registered manager told us they were using more agency workers than they would have liked. On the first day of our inspection on the 12 June 2015, we spoke with two agency workers. We found they did not have the necessary skills and experience to support people with complex behaviours.

Hunters Moon supports people with complex needs . The agency workers had not undertaken training in breakaway or restraint techniques to ensure that they and service users were not harmed if a physical challenge occurred. Neither agency worker had received training in epilepsy awareness yet were monitoring people who were prone to high level of seizures. One agency worker told us they had seen a seizure but would not know what to do. Both agency workers were told to 'shout' for a permanent member of staff if either person showed signs of a seizure. However, this posed a risk if staff could not hear them.

We asked the deputy manager how they knew that the agency workers had the right skills to support people safely. They responded that the agency 'know what we need'. We asked the registered manager to supply us with a copy of a service level agreement with the agency which evidenced what skills and experience agency staff should have when they worked in the home. They were not able to supply this or any documents which evidenced the skills and experience of the agency workers they contracted to work at the home. This meant that people were at risk because the agency staff we had spoken with did not have the necessary skills and experience to support people safely and appropriately.

Prior to our inspection we attended a local authority safeguarding meeting with regard to medicine errors made by staff at Hunters Moon. One person had not received the required dose of their medicine and another person had not received their medicine as required. The type of medicine for which the errors were made were anti-psychotic and anti-convulsant drugs. Missing this type of medicine or not taking the required dose could have a severe impact on the person.

The outcome of the safeguarding meeting was that an action plan was put into place to ensure people were safe and to address the issues of staff competence when administering medicines. The provider was to purchase medicines cabinets. These would go into people's room and would allow staff not to be disturbed whilst they administered the medicines. This mean't that the risk of making an error due to staff being interrupted was reduced. Staff were to receive further training in administering medicines. The deputy manager was to monitor that medicines were being administered safely.

The registered person was failing to safeguard service users from abuse and improper treatment. This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered

Inadequate

Is the service safe?

person was failing to protect people with regard to the proper and safe management of medicines. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they thought people were 'much more relaxed and happier" and people confirmed this. Families commented “no reason to think my son is not safe”, “I have never felt they are particularly at risk” and “I am confident my son is safe”.

Risk assessments were used to identify what action needed to be taken to reduce potential risks which people may encounter as part of their daily living. The risk assessments formed part of the person's care plan and gave guidance on how care and support should be delivered to keep people safe and to enable them to maintain their independence. Such as travelling in a car, where the risk assessment gave actions to ensure the person and staff were safe whilst travelling. Some people could put themselves or others at risk of harm if they became anxious or upset. Staff told us they received training in positive management behaviour support. Staff were aware of what might trigger different types of behaviour and were able to intervene at an early stage in order to de-escalate and prevent incidents.

During the two days of the inspection, we saw there were high levels of staffing and staff were visible and available to people at all times.

Environmental risk assessments were in place to ensure the home and the surroundings were maintained and safe for people. Weekly fire testing was carried out and equipment was maintained for wear and tear. In the event of an evacuation of the premises, each person had a plan which told staff what support the person required to be able to safely evacuate the home.

Requires improvement

Is the service effective?

Our findings

Staff told us they had received supervision but not on a regular basis and records evidenced this was the case. The registered manager confirmed that staff supervision had fallen behind. Out of a care team of 17 care staff, five permanent care workers had not received supervision in 2015. The remaining 12 care workers received supervision between January 5 and 1 February 2015. In addition, the registered manager told us that staff had not received an appraisal within the last year and a half to two years. Due to a lack of regular supervision and appraisal, the registered manager could not be assured that staff were improving the quality of the work they do through achieving their agreed objectives and outcomes.

Some of the supervision records completed did not have sufficient detail. This was in response to questions such as in safeguarding people, or information about progress and development of staff, and in particular, areas where further development was required.

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

The Care Quality Commission is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The Mental Capacity Act 2005 sets out what must be done to make sure that the rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care or treatment. This includes decisions about depriving people of their liberty so that they get the care and treatment they need where there is no less restrictive way of achieving this.

The service had complied with the requirements of the Mental Capacity Act 2005. Where required, mental capacity assessments had been undertaken and DoLS applications had been made. Best interest meetings had been held to ensure that decisions made were in the interest of the person. People and their family were involved, as well as relevant health and social care professionals and staff from the home.

Staff said they were happy with the training offered by the provider and felt they had received sufficient training for their role. Training included mandatory subjects such as manual handling, positive behaviour management and safeguarding vulnerable adults. Staff completed specific training to support people's individual needs, such as autistic spectrum disorder, epilepsy awareness, sensory training and supporting people with a learning disability. During our conversations with permanent staff, we found they were very knowledgeable about the people they cared for and skilled in supporting each person's individual needs.

People told us they liked the staff and we observed there were positive interactions between people and staff. We observed staff communicated with people effectively and used different ways of enhancing that communication. This included, touching people on the arm to gain their attention, giving eye contact and affording people time to respond to any requests or questions. Some people used signs which were individual to them. We saw staff understood people's communication and were able to readily respond in a way which the person understood.

People told us the food was "good", "I like lasagne and pizza" and the food was "nice". People had access to a choice of food and drink throughout the day and staff supported them when required. One person helped peel the potatoes ready for the evening meal, they told us they "liked to help in the kitchen". Meal times were variable, depending upon when people got up in the morning or when they were ready to eat. People were offered a variety of different types of food and alternatives if they did not like what was on the menu for that day.

Each person had a health action plan which identified their health needs and the support they required to maintain their emotional and physical well-being. This helped staff ensure that people had access to the relevant health and social care professionals.

Relatives told us they had a good relationship with the registered manager and staff and commented "I feel well informed" and "I am kept informed most of the time". A range of easy read and pictorial information was available to people, such as the care plans, how to make a complaint and timetables. This empowered people to be involved in their care and support.

Good

Is the service caring?

Our findings

Relatives told us “he is well cared for”, “the service is generally caring” and “the care is excellent”. People told us they liked the staff and told us the names of staff they liked.

The accommodation at Hunters Moon was spacious and we saw that people wandered around freely as they wished or with support from staff. The home was well lit and appropriately furnished. People had personalised their rooms as they wished.

Staff were kind, friendly and caring towards people. We saw that people and staff had developed positive relationships. Staff spoke with people in a respectful manner and gave people time to respond. Staff used humour to engage with people when supporting with daily routines and people responded well to this.

When staff entered the communal rooms they acknowledged people and called them by their preferred name. People were treated equally and we saw that staff were aware of people’s personalities and respected their right to do things in a particular way, change their mind or do things differently. Staff explained to people when personal care was needed to ensure they understood and consented. All personal care was carried out in the privacy of the person’s room

People's dignity and privacy was respected. The registered manager told us they had to ensure that people who had epilepsy were monitored when they used the toilet in case of a seizure. We saw that one person was assisted to the toilet, with the staff member close by and the door slightly ajar. They monitored by listening and verbally checking in with the person. As the member of staff was close by, they were able to respond in an emergency but also respected the person’s privacy and dignity.

People who live at Hunters Moon had complex needs which required varying levels of support. Staff were knowledgeable about the people in their care and were mindful of people’s emotional wellbeing. We saw that if individual people were agitated or distressed, staff used effective techniques to reassure and calm them. Staff told us that as some people could not verbalise their wishes clearly they looked for other ‘cues’ such as facial expressions, sounds or actions, such as the person clapping their hands if they were happy.

Relatives told us that they felt involved in their family members care, comments included “personal care has improved”, I am kept well informed of what is going on” and “I was concerned about my son losing weight, I made a suggestion about this and they listened and acted upon it. Their weight has stabilised, he looks so well and very, very happy”.

People had access to advocacy support with regard to making decisions about their care and support and finances. An advocate supports people to understand their rights and encourages them to speak up if they need information to make an important decision or are unhappy about how they have been treated.

Good

Is the service responsive?

Our findings

Staffing levels were on a one to one basis which enabled staff to quickly respond to people's requests for support. Each person's room showed their individuality and the things that were important to them, such as music, DVD's and family photographs. One person had just had their room decorated to a 'more grown up style'.

Each person had a care plan which was tailored to their individual preferences and abilities. There was detailed information about the level of support people required in relation to their health, mobility, social and personal needs. Risk assessments were in place which enabled staff to keep people safe and maintain their independence.

Behavioural support plans were also in place which included the involvement of the mental health team who provided guidance and support to staff on managing behaviours that may challenge. Care staff told us the information and guidance given in the care plans enabled them to safely and consistently deliver care and support in the way in which people wanted.

People and their relatives had been involved in the discussions and planning of their care and support and care plans were reviewed regularly. One relative told us "I am fully involved in my son's care. The registered manager rings me up and speaks to me at least once a day". Care plans were signed by people or their relatives to show their agreement with the support which was given and how the care would be delivered.

People's preferences for the way their care was delivered was clearly documented in their care plans. From decisions about what to wear, to personal care routines and daily routines to likes and dislikes with food. Staff told us they supported people to visit their family and a relative confirmed that their son visited them three weekends out of four. There were no restrictions on when family and friends could visit the home.

We observed that people decided how they wished to spend their time. Some people went out for a walk, for a drive in the car or listened to music. Other people watched the television, stayed in their room or 'dozed' in a 'chill out' room. A member of staff helped one person make a friendship bracelet and they told us about a village fete they were looking forward to going to. A relative said "my son is provided with a good level of quality activities".

Families and staff told us that people went swimming, visited their family home, enjoyed music concerts and visited the local pub for meals. For one person, a train trip had been arranged as a birthday treat and another person grew their own fruit and vegetables in the garden, which they sold to the home as a way of supplementing their income. The registered manager told us they were continuing to look at ways of providing meaningful activities which people wanted to do.

There was a complaints procedure in place and staff told us they knew when people were not happy. One member of care staff told us "people will either tell us if something is wrong or it may be through their body language or their manner". Relatives told us they had no complaints and felt that the registered manager and staff listened to them if they had concerns. The complaints procedure was available to people in an easy to read and picture format.

Inadequate

Is the service well-led?

Our findings

A statutory notification was not submitted to the CQC as required when the police became involved in the investigation into the allegation of abuse at Hunters Moon.

The registered manager was not aware that staff should have the opportunity for an annual appraisal. This had been a requirement since the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The culture within the home did not evidence an open and transparent culture where abuse was not tolerated and where staff felt able to raise concerns without fear of recrimination. Staff told us that they did not raise concerns about the abuse because they felt intimidated by the two staff members, who had since been dismissed. The registered manager failed to promote an environment where staff could come forward and be confident their concerns would be listened to.

The registered manager demonstrated a lack of managerial and leadership skills in addressing the conduct and behaviour of the two staff involved by enforcing the disciplinary procedures when required. Staff were not supported in ways that were consistent with their role and responsibilities to ensure that professional boundaries were adhered to. The deputy manager had not received formal supervision and the informal meetings they had with the registered manager, were not documented.

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

There was a registered manager in post at Hunters Moon who was supported by a deputy manager. Families told us that “he [the manager] is doing a good job and has got on top of things better than previous managers” and “a very good manager”. Staff told us they were happy in their role and felt valued by the registered manager and the provider. The staff we spoke with told us they were now more confident they would raise concerns with the registered manager because the staff involved were no longer working at the home.

The management of the home and the provider quality assurance team carried out audits on a monthly and quarterly basis. There were contingency plans in place in the event of the loss of facilities, such as gas or electricity or the evacuation of the premises. The building and the environment were audited by the registered manager to ensure internal and external areas were well maintained. There was a development plan in place for the home with regards to the internal décor and maintenance. The deputy manager told us they carried out night spots checks as part of their quality auditing systems. Training had been audited and people knew what training they had attended and what they need a refresher course and when.

Within the community, the chairman of the fete committee in Yatton Keynell had ‘applauded the work which Hunters Moon did'. The home felt they worked well with all agencies and professionals and that staff were dedicated in their work. There were many compliments from families of the people who live at Hunters Moon.

The registered manager was part of the Provider Association for Wiltshire. They also accessed resources through publications and websites such as Care Matters, Challenge magazine, Caring UK and the CQC website. They also attended meetings with other managers at other Homeleigh Care Homes Limited locations.