Quality Care (EM) Limited

The Hollies

Inspection report

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Ratings

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

Overall summary

This inspection took place on 1 February 2016 and was unannounced.

The Hollies provides accommodation and care for up to 21 people with learning disabilities in six purpose built bungalows and three individual apartments. There were 20 people living there when we visited.

There was a registered manager who was available throughout this inspection visit. 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 protected from harm at The Hollies. Any risks to the safety of people were assessed and reduced as far as possible. There were enough staff available to meet people's individual needs and action was taken to ensure people received their medicines safely.

Summary of findings

A range of training was available to staff and they had information about the Mental Capacity Act and the manager ensured people's rights were protected

People received appropriate support with their eating and drinking needs, their independence was promoted. People received their preferred choice of meal and were involved in food preparation where possible. People's ongoing health was monitored and health needs were met.

All staff showed kindness and compassion in the way they spoke with people. People were supported to maintain relationships with family and friends and there were no restrictions on visitors. Staff showed respect for people's privacy and dignity. They understood the importance of confidentiality, keeping all personal information about people safe and secure.

The service was responsive to individual interests and preferences, and plans of support and care were specific to people's individual needs. People were satisfied with responses they had received when they raised any concerns.

There were systems in place for the registered manager to ensure all areas of the service were regularly checked and the overall quality of care was monitored by the care director on behalf of the provider.

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 safe.

Staff understood what action they needed to take to keep people safe and action was taken to reduce personal risks to people's health and welfare.

People were supported by a sufficient number of staff being deployed in the right places to meet their needs safely. New staff were always thoroughly checked to make sure they could safely work with people at the service.

Medicines were managed to ensure people received them safely.

Good

Is the service effective?
The service was effective.

New staff had a structured induction and received further training to meet people's needs.

People received appropriate support to ensure they were eating and drinking healthily. Also, they had the support they needed to see their doctor and other health professionals at home or in hospitals.

People's rights were protected by the use of the Mental Capacity Act 2005 when needed.

Good

Is the service caring?
The service was caring.

People were cared for by staff who showed kindness and compassion in the way they spoke with people.

Independent advocates were available to represent people's views when needed.

People's privacy and dignity were respected by staff.

Good

Is the service responsive?
The service was responsive.

Care was personalised and responsive to people's needs. Activities were available to meet people's individual preferences and interests.

People's views were listened to and there was a system in place to respond to any complaint.

Good

Is the service well-led?
The service was well led.

The registered manager was based at the service and made frequent visits to people in each bungalow and apartment. Management arrangements were in place to support staff when needed.

The quality of the service was regularly monitored by the provider.

Good

The Hollies

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 1 February 2016 and was unannounced. It was carried out by two inspectors.

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. We reviewed the PIR and other information we held about the home, which included notifications they had sent to us. A notification is information about important events which the provider is required to send to us by law. During the course of this inspection we also contacted health and social care professionals for their feedback about the service.

During the inspection, we spoke with four people that were using the service. We also spent time observing the care and attention other people were receiving.

In addition to the registered manager, we spoke with three team leaders, a deputy team leader and eight support workers. We reviewed some records, including the care records of seven people and records relating to staffing, accidents, incidents and complaints.

Good

Is the service safe?

Our findings

People were protected from avoidable harm and abuse. Three people that we spoke with told us they felt safe where they lived. One person said, "I like it here and staff make sure I'm safe."

Staff were aware of the signs of abuse and what their role and responsibility was in protecting people from abuse and avoidable harm. This included recording and reporting any concerns to the team leader or registered manager. They said they were confident appropriate action would be taken. Additionally, staff told us that they had access to the provider's safeguarding policy and procedure. One staff member said, "We make sure people are safe at all times." Another told us that safeguarding people was a major part of health and safety, which was always given priority during training. Staff gave us examples of how they had managed situations where people may have been at risk due to their own behaviour. They referred to the positive behaviour management training they had received. Staff said that any restrictive holds were a last resort and rarely used. One staff member told us, "We're aware of some personality differences between people and provide support such as verbally redirecting if a person is becoming agitated towards another person."

In the care records we saw that risk plans had been developed to advise staff of how to manage and reduce any risk to people's safety as far as possible. Staff told us that they found risk plans informative and provided appropriate guidance and support. Additionally, staff said that any concerns about risks were discussed in staff handover meetings and risk plans were regularly reviewed. A team leader told us that accidents and incidents were discussed in staff team meetings to share ideas about what action was required to reduce incidents from reoccurring. This helped to keep people safe.

We found the environment was safe in meeting people's individual needs. All accommodation was within safe and secure grounds that minimised restrictions on people's freedom. For example, we saw people accessed the garden area independently. People who used the service experienced periods of high anxiety that resulted in behaviours which meant they could be at risk of injury within any environment. The internal environment had been assessed appropriately to meet people's individual needs. Staff showed a good understanding of safety issues in relation to the premises and how hazards and emergencies were dealt with.

Staff said they felt that, although there had not always been enough staff in the past, this had improved recently and they now had enough staff on duty to meet people's needs safely at all times. They told us that any staff sickness days and holidays were covered by staff working additional hours. Staff told us that they usually worked in the same bungalow or apartment to provide consistency and continuity. Three support staff said they sometimes agreed to cover for other staff in other areas of the service, but found it more challenging due to being unfamiliar with some people's needs. However, there were always other staff on duty that knew the people well.

The registered manager told us they used a "care funding calculator" which helped them to calculate how many staff were needed in each area based on people's individual support needs. There were rotas showing where staff were based for working with people. This took account of where and when people required one to one support and there were additional "floating" staff who were allocated to assist where needed. The provider also employed further bank staff who were available to assist when other staff were sick or on holiday. We found on the day of our inspection there was sufficient staff on duty to meet people's assessed needs and keep them safe.

There were safe staff recruitment and selection processes in place. Three staff told us told us they had supplied references and undergone checks relating to criminal records before they started work at the service. The registered manager showed us some records which confirmed the recruitment process ensured all the required checks were completed before staff began work. There were additional records to show that the registered manager had thoroughly assessed the outcomes of these checks. This process was to make sure, as far as possible, that new staff were safe to work with vulnerable adults.

One person told us, "Staff look after my tablets and I'm happy with the way they give them to me." We saw that medicines were stored safely and securely in the bungalows. However, where one person had moved to an apartment, we found further security was needed. We discussed this with the registered manager and a team leader who were in the process of obtaining a specially

Good

Is the service safe?

designed storage unit in line with good practice guidance and legal requirements to ensure all medicines were stored securely. A team leader confirmed the order a few days after our visit.

We found liquid medicines and topical creams were labelled with the date of opening with one exception of one particular cream, which was immediately removed by a member of staff and another tube found was made available to use if needed. Staff had directions about where and when topical creams should be applied and body maps were used to clarify this if needed. One of the staff explained the systems in place for the timely ordering and supply of medicines. Staff told us that they had completed medicines administration training and had also observational competency assessments carried out by the team leaders.

We saw the medicines administration records (MARs) for the current month. These documents record the each person's medicine details and staff initials to confirm the medicines have been administered to the person. A team leader told us they checked the records each day and if any initials were missing they checked the stock of medicines with staff on duty at the time, to make sure they had been taken. We saw most MARs were fully completed, though some initials were missing in one bungalow.

There was a record of any allergies and detailed information about people's preferences of how they took their medicines in their care plans. Protocols were in place for medicines which had been prescribed to be given only as required (PRN) and these provided information for staff on the reasons the medicines should be administered. We noted, in one bungalow, one person's support plan in relation to their PRN had not been updated since the GP had increased the dosage of the medicine. However, it was clear on the MAR sheet and staff told us they had been made aware of this change. So, although there were some inconsistencies in one bungalow, medicines were generally managed so that people received them safely.

Good

Is the service effective?

Our findings

One person told us, "I know staff have done some training, 'cause they know about things and how to help people." Our observations confirmed people were supported in accordance with their support plans.

In discussion with staff we found they were knowledgeable about people's individual care and support needs. Staff told us about the induction training they had received when they commenced employment at the service. One staff member said, "The induction is organised and is good at preparing you for the job." Five of the staff we spoke with were positive about all the training opportunities they received. They said that training was supportive and relevant to people they cared for and gave examples of the training they had completed. These included autism awareness, epilepsy, dementia, diabetes, first aid and fire safety. One staff member said, "You can request additional training and ask for one to one training if you need it." Staff told us their practice had been observed by team leaders and they received feedback which they found helpful. Experienced staff told us they used to have regular training, but had not had any recently. One staff member said they had not received any classroom training for two years. Another member of staff told us that work training books had been introduced as a new method of training. The registered manager told us the work training books were completed by all staff, but some staff did not recognise this as training. There were records of staff receiving training in this way. Experienced staff had pursued further training and had national vocational qualifications.

Some staff told us of regular opportunities they received to meet with their line manager to discuss their work, training and development needs. They said this was in six or eight weekly individual meetings, but this was not the case for all staff. One staff member said, "We have six weekly one to one meetings and regular bungalow meetings." Another staff member told us, "I've not had a supervision meeting for three months, but the team leaders are approachable." An additional staff member told us, "The last bungalow meeting was four or five months ago." We discussed this with the registered manager, who told us immediate action would be taken to improve the frequency of individual supervision and team meetings. A few days after our visit the registered manager confirmed further systems had been put in place to ensure all staff had regular formal opportunities to meet with a team leader so they could regularly discuss their work, training and development needs.

Three people told us they made their own decisions about what they did each day and the support they needed. One person showed us their activity programme which detailed their own choices of what they wanted to do. They said, "I can change things if I want to." Staff told us they always involved people as far as possible in how they wanted to be supported. We saw some examples where people had signed their support plan to show that they had given consent to the care and support they received. We also observed that staff supported people effectively with making day to day decisions about the care and support they received.

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.

People can only be deprived of their liberty to 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 are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. The staff understood how best interest decisions were made using the MCA. We saw that a two stage test was used when needed. The plans were clear about the support that people needed to make some decisions in their best interests.

All staff had received induction training on the Mental Capacity Act (2005) (MCA) and demonstrated through discussion that they knew when they needed to act in people's best interests. We saw examples of where some people did not have full mental capacity to make some decisions and there were appropriate assessments and specific plans to direct staff to act in people's best interests. There were records to show that advocates and relatives had been involved in decisions. However, we saw some inconsistencies such as best interest decisions that had

Good

Is the service effective?

been made without the mental capacity assessment being completed. We also found some examples where mental capacity assessments had not been considered for specific decisions such as managing people's monies. We discussed this with the registered manager who made a note to check these immediately.

Staff were also aware of the Deprivation of Liberty Safeguards (DoLS). We saw that staff were following the conditions of the DoLS that had been agreed, so that no one was being unlawfully restricted in any way. We saw one example where a condition had initially not been fully followed, but there was a record of a change made with improved communication and a reminder to all staff that joint working was required.

Staff were highly aware of the risks posed due to the way some people behaved when they were expressing their distress. Staff gave us examples of how they had managed some situations where people may have been at risk due to their own behaviour. Behavioural strategy plans were detailed and provided staff with good guidance. Staff said that any restrictive holds were only a last resort and rarely used. Staff told us they had received training in this during their induction. We saw information about this training, which detailed a well-recognised accredited method of restraint. There were records of incidents and staff had the chance to discuss and reflect on their actions. We also discussed this with the registered manager who told us of the action that was taken to continually improve staff members' consistency of approach so that the all way staff met the challenge of some people's behaviour was effective and least restrictive.

People were supported to eat and drink and maintain a balanced diet based on their needs and preferences. We observed people being given a choice of meals and drinks. Three people told us they were happy with all the food they had. We looked at the menu plan and food stocks, we found people were offered a choice of what to eat and fresh vegetables, salad and fruit was available to support health eating choices. There were photographs of food to assist some people with their choices. Staff told us that people were involved in the development of the menu as far as possible and also with the food shopping. Some people that used the service made snacks and drinks with support from the staff, who encouraged them to develop their food preparation and cooking skills. One person told us that they cooked a meal once a week for everyone in their bungalow, with support from staff. Another person told us it was planned that they would go out for their evening meal once a week and they looked forward to that too.

People's dietary and nutritional needs had been assessed and planned for individually in diet and nutrition plans that we saw on people's files. The plans showed us that consideration of people's cultural and religious needs was also given in menu planning. We saw that one person used adapted utensils that promoted their independence with eating. People were weighed on a regular basis to enable staff to monitor their weight so action could be taken if changes occurred. We saw examples where people had been prescribed food supplements and observed a person being given their supplement. Staff told us that they had attended food hygiene training and that they encouraged people to eat healthily. An example was given how staff were supporting a person on a healthy eating plan to reduce weight which the staff team were also following

We saw there were records of the involvement of various health and social care professionals in people's care including the GP, psychiatrist, and speech and language therapist. People were also supported to maintain their health and accessed health services such as the dentist and optician. This was recorded on each person's 'Health Action Plan' (HAP). These are specific plans to clarify what a person needs to stay healthy. All professionals who support people's health needs were listed, along with various appointments. One person told us that they often looked at their HAP with staff and a staff member said that they discussed HAPs regularly with people or their relatives. In addition, we saw people had 'Hospital Passports' within their care plan files. These documents provide hospital staff with important information such as the person's communication needs and physical and mental health needs and routines. This demonstrated the provider used best practice guidance.

A healthcare professional told us, "I am aware of one member of staff who went above and beyond to support an individual who was admitted to hospital at short notice to have an urgent operation and the parent was extremely grateful for the support they were given." Staff also gave us good examples of how they monitored people's healthcare

Good

Is the service effective?

needs and recorded their observations in daily records; this included the signs of any infections. This all showed us that people's ongoing health was promoted, supported and monitored.

Good

Is the service caring?

Our findings

One person told us, “I like it here and I like my staff. They care about me.” Another person said, "They’re brilliant and caring. They help me out if I need it.” We observed consistently positive interactions between staff and people using the service. Staff acknowledged people when they passed by and spent time talking to them. They spoke with affection for the people using the service and we saw that people were relaxed with them. We heard people’s preferred names being used at all times. We saw positive caring interactions of staff meeting people’s needs. For example, we observed how a person who had become anxious was supported to relax and be occupied with activity that relaxed them and that they enjoyed.

One person we spoke with told us that staff involved them in discussions and decisions. They said, “They’re good, the guys [staff] ask me what I want to do.” Another told us they had ‘rules’ and had signed their agreement to them. They said they liked having rules to live by. We observed staff supported people with everyday decisions such as involving them in decisions about what they ate, drank and how they spent their time.

Staff told us how they tried to encourage and involve people as fully as possible. They told us of the different communication tools they used to support people with their communication needs. This included using photographs and other pictures, simplified sign language and gestures, as well as various objects to provide a reference to an activity and the options to choose from. For example, when encouraging people to choose their clothes, they always set out to pieces of clothing, so people could point or take which they wanted to wear. Whilst we did not see all of these communication tools in use, staff used clear verbal communication and listening skills. At times they were able to correctly anticipate some people’s needs and gave people time to respond to questions about options and then acted on people’s choices. There were photographs of staff who were regularly employed in each bungalow. Team leaders were arranging to update these with photographs of newer staff so that people had them as a reference.

There was little evidence of people participating in the formal reviews of their care and support. However, a team leader told us, and the registered manager confirmed that they were going to return to having three monthly internal review meetings. They said that people would be involved as fully as possible and relatives and advocates also invited.

One staff member told us of regular telephone contact with various family members so that people were supported to maintain relationships with their families. Some visited the home regularly and some people were supported to visit their family members at their home. During our visit one person had staff support and transport provided to visit their family member. A team leader told us how some people were supported by independent advocates that regularly visited them. Their role was to support the person and represent them in discussions and decisions about the service they received. We saw evidence from care records of independent advocates visiting people.

Staff told us about how they showed respect for people’s privacy and dignity. One staff member explained how they were always discreet when assisting people with their personal care, encouraging people to keep parts of their bodies covered and keeping curtains closed until they were fully dressed. We observed staff knocking on people’s doors before entering their room and taking steps to protect their privacy. There were care plans that detailed the ways in which care should be provided in order to protect people’s privacy and dignity and there was a record of whether the person had a preference for a male or female member of staff to support them with their personal care needs.

In one of the bungalows we saw people had personal information displayed on the notice board. We were concerned that visitors had easy access to this personal information. The team leader agreed to remove this information. All other confidential information was stored securely and accessible only to those people that needed it in the interests of people living there.

Good

Is the service responsive?

Our findings

The service was responsive to individual interests and preferences. One person who used the service told us about their interests and hobbies and how staff supported them with these. Another said, "I can watch my films when I want." They showed us the range of DVDs they had in their room and indicated their favourites. Staff on duty were fully aware of the favourite choices and helped the person to set them up to watch. People told us of other activities, including going to a snooker hall, shopping trips, other outings and various holidays. A person told us how they were supported to access the local community and visited the local pub where they played pool and darts and was happy to report they had, "Got friendly with the locals."

Care and support plans contained detailed information regarding people's needs, their life histories and their preferences. Much of this information had been gathered when people first moved into the service. Staff told us that people had a detailed, planned and structured transition period when moving to the service. This was to fully assess the person's needs to ensure they could be met appropriately. Support plans were then developed to advise staff of people's needs, routines, preferences and what was important to them. Some people had limited verbal communication and communication support plans were detailed and specific to the person's needs. This enabled staff to interpret and respond to people's individual communication needs appropriately. Plans were regularly reviewed by key workers. The care plan files contained a sheet for staff to sign when they had read any updated information. In two plans we saw there were 'post it' notes indicating the changes that the team leader needed to include in the next evaluation and update of the full plan. The staff told us they read the information when they had time between tasks, but they also recorded daily activities and incidents which they handed over to the next shift of staff. In this way they always had current information about how people were and any changes in their needs.

Support plans also included and promoted life skills and independence. Such as people being involved with daily living tasks of laundry and cleaning. One person told us how they did their own laundry and cleaned their bedroom with the support of staff. We saw another person engrossed in these tasks. People were also encouraged to develop literacy and number skills. There were activity workbooks for this purpose, which allowed people to work at their own pace.

Staff demonstrated that they knew what interested people by telling us about the specific activities, interests and hobbies people had and how they supported them with these activities. One person told us how they enjoyed fishing and that a particular staff accompanied them for this activity. Additionally, we saw activities such as arts and crafts, board games, music and exercise equipment such as an exercise bike was available for people. All these showed us that staff responded to individual needs and were flexible in changing activities in response to anyone's change in mood and behaviour.

For people that chose to be outside, we saw that they had safe and easy access to outdoor space. Internally people had spacious bedrooms that had been personalised to people's individual needs and preferences.

All activities for each person were set out on individual activity plans for each week. A team leader told us they always kept a record of activities people chose and participated in. They said that this was important to find out what worked well and what did not work well for people. We saw records that confirmed what we were told.

A social care professional told us, that the staff responded well to individual people's needs. They said, "They have always gone over and above expectations and worked well with the people."

The service listened to people and responded to any issues or concerns promptly from members of the public and any outside agencies. One healthcare professional told us, "The staff are very receptive happy to help, take advice and act upon it." Another said," On the one occasion I have expressed a concern to the manager he listened and gave advice and support to the team and expressed that they returned to him if the situation continued."

One person told us they did not know what the complaints procedure was, but they did not have any complaints about the service at all and if they were concerned about anything they would tell their key worker or the registered manager. There was a set procedure for dealing with complaints and staff said this was made available to people in information packs as well as on noticeboards. We saw an example of a pictorial complaint procedure on

Good

Is the service responsive?

display for people. This used a symbols communication tool that was not easily understood by most people, but staff told us they would explain it if anyone wanted more information. They said they would know if people wanted to make a complaint about their care, as they could tell from their behaviour during the time they spent with people. One of the staff told us that, if necessary, they would write down in detail any complaint they received to pass on to the registered manager.

The registered manager had no record of any formal complaints, but had responded to concerns raised by a member of the public. In this instance, the complainant was also offered an opportunity to visit and discuss their concerns, but had not taken up the offer. A family member of one person had expressed their concerns by email and this had led to a full review of an aspect of the person's care, with further reviews planned at regular short intervals. The family member was satisfied that the registered manager was responding appropriately and making the changes needed.

Good

Is the service well-led?

Our findings

We found there was a positive culture amongst the staff who had a strong understanding of caring and supporting people. The positive attitude was promoted by the provider through the registered manager and team leaders, who led by example whenever they had the opportunity. Staff had regular contact with people's families, with their consent, so that they were always included in what was happening at the home. Staff were clear about the aims and values of the service. One staff said, "Some people will go on into supported living, our role is to support them to gain the independence and confidence to do this." Another staff member told us, "We provide a homely environment; staff are very caring and treat people as they would their family."

There was a registered manager who visited each bungalow and the apartments most days. One staff member said, "The manager comes across [from the administration office] and says 'hello' I know he's there if we need him." Staff told us they were encouraged to tell the manager if they had any concerns at all, such as if they did not feel there were sufficient staff available to meet someone's needs. There was an 'on call' system so that the registered manager or team leader was available at nights and weekends. Any staff could contact a manager if needed. There were regular management meetings attended by the registered manager and team leaders, with action points circulated afterwards to assist team leaders to pass on information to other staff.

We found some inconsistencies in the way the service was managed on a day to day basis within the bungalows. There were six bungalows and three team leaders that provided the supervision and support. Most staff spoke positively about the team leaders who they described as supportive and approachable and who knew the people who used the service very well. Some staff told us they not had any supervision meetings or bungalow team meetings for over three months. From comments made by staff we found there were differences in the way their team manager communicated information to them. We were concerned that some staff may not have had all the up to date information or support they needed to meet people's needs. We discussed our concerns with the registered manager who immediately commenced a plan to eliminate any inconsistencies. This was by increasing the frequency of when he supervised team leaders and developing clear plans to ensure all other staff had regular opportunities to discuss their work, training and development needs. The manager quickly developed forms to monitor the performance of each team leader.

We had received notifications of the incidents that the provider was required by law to tell us about, such as any restrictions, allegations and other concerns. Appropriate action was described in the notifications and during our visit, we were able to see records in a file of incident reports that showed how everyone had learned from incidents with further actions taken where needed.

The care director visited the home regularly on behalf of the provider company and monitored the quality of the service through supervising the registered manager and then reporting to board meetings. Staff and the registered manager told us there were systems in place for the registered manager and team leaders to be responsible for checks made and to monitor the day to day quality of the service. We saw daily checks were completed on the medicines and on money kept on behalf of people. We also saw records of environmental checks that included firefighting equipment and emergency lighting. The records showed these had been checked a week before our visit.

There was a system to seek and act on feedback from people using the service and other persons on the service provided. The care director had completed a full audit of all the provider's services over a six month period from February 2015 to August 2015 with an emphasis on the action points that arose from the previous year. This involved face to face discussions with people and completion of survey questionnaires as appropriate. The views of people at the service, their relatives and other interested parties were included with the views of staff. A copy of the audit was provided for us and it was also made available through a link on the provider's website. The outcome of the whole audit was positive and all those involved had welcomed the opportunity to be able to make suggestions and offer constructive criticism. The next full audit was due to commence after this inspection. It was clear that the registered manager and provider company were keen to continue to provide a good consistent quality of service at all times.