Torbay and South Devon NHS Foundation Trust

Baytree House

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

Baytree House was registered under Torbay and Southern Devon NHS Foundation Trust (the Trust) in October 2015 as a service providing respite care for up to eight people with learning disabilities. This was the first inspection of Baytree House under this provider, although the service has been established for many years as a location under the previous Care Trusts registration.

This inspection took place on 3 and 4 February 2016. The first visit was unannounced, and both visits took place over the afternoon and evening to enable us to meet people coming to the service for care. There were six people using the service on the days of the inspection, one of whom spent a night away between the two site visits.

Baytree House primarily provides a respite service for people with learning disabilities. People using the service may have complex needs including physical disabilities and difficulties with moving independently. Some of the people using the service have done so for many years and so are very familiar with Baytree House. One relative told us it was a “home from home” for their relation. We were

Summary of findings

told that people requested their favourite themed bedrooms when they booked a visit, and that consideration was given to who else might be staying at the time to ensure people got on well wherever possible. Some people using the service were familiar with each other as they used the same day services.

People or their relatives told us they were happy with the services provided by Baytree House. The service was used flexibly to provide respite support to carers who supported people in their own homes, which might be for a regular one night stay each week. Other people were staying for a longer period of a fortnight whilst their carers had a break. For some people the home had provided emergency longer term respite until a new permanent placement could be found for them.

We saw many examples of positive and supportive care being delivered. Systems were in place to protect people from abuse or report any concerns about people's well-being. Staff respected people's confidentiality, privacy and dignity, and were aware of people's communication needs or methods. They were skilled in interpreting what these meant for people who were not able to express themselves verbally. People were encouraged to retain their independence and skills they used at home. People and relatives had been involved in making their care plans and sharing information about people's needs and wishes in relation to their care. Care plans gave clear information about how people wanted their care to be delivered and were updated regularly.

There were enough staff to deliver care to people, and staffing levels were reviewed and changed every day to reflect the needs of people staying that day. Staff recruitment practices ensured that a robust process was being followed, including taking up of references and disclosure and barring (police) checks. Staff had received the training they needed, and this was updated regularly. Staff supervision and appraisal systems were in place, and the staff told us they felt supported.

Risks to people were assessed, and actions taken to reduce any risks where possible. Incidents and accidents were analysed to help assess how they could be prevented. Risk assessments in relation to the premises were up to date, and any concerns were raised with senior people within the Trust. Safe systems were in place for the management of medicines.

People's rights were being protected because the principles and implementation of the Mental Capacity Act 2005 (MCA) were understood and put into practice. People were asked for their consent before care was given and where there were concerns over people's capacity to make decisions, best interest decisions were made and recorded appropriately on their behalf. No Deprivation of Liberty Safeguards were in place or needed.

People enjoyed their meals and people's dietary needs and choices were respected.

The building, although not ideal was being reviewed to ensure it met people's needs. We have made a recommendation in respect of taking specialist advice on the adaptation of the premises to support people with sensory impairment.

There were effective systems in place for good governance, quality assurance and safe care for people at the service. The service's management demonstrated good leadership. There was an open culture and people were encouraged and enabled to have a say in the way the service was run. People told us the manager was approachable and a good leader, with a clear understanding of people's care needs. Complaints management systems were robust.

People took part in regular resident's meetings and had themselves elected a Champion to represent their views at staff and management meetings. Questionnaires were sent to people as part of a quality assurance exercise and changes made as a result. For example the service had purchased a tablet computer for people's use.

Records were well maintained, although some were still in the process of being updated to reflect Torbay and Southern Devon NHS Foundation Trust as 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?

Good

The service was safe.

Systems were in place to protect people from abuse or report any concerns about people's well-being.

There were enough staff to deliver care to people, and staffing levels were reviewed and changed every day to reflect the needs of people staying that day. Staff recruitment practices ensured that a robust process was being followed to ensure staff were suitable to be working with potentially vulnerable people.

Risks to people were assessed, and actions taken to reduce any risks where possible. Incidents and accidents were analysed to help assess how they could be prevented. Risk assessments in relation to the premises were up to date, and any concerns raised with senior people within the Trust.

Safe systems were in place for the administration of medicines.

Is the service effective?

Good

The service was effective.

Staff had received the training they needed, and staff supervision and appraisal systems were in place. Staff told us they felt supported.

The principles and implementation of the Mental Capacity Act 2005 (MCA) were understood and put into practice.

People enjoyed their meals and people's dietary needs and choices were respected.

The building, although not ideal was being reviewed to ensure it met people's needs. We have made a recommendation in relation to meeting the environmental needs of people with sensory impairment.

Is the service caring?

Good

The service was caring.

We saw many examples of positive and supportive care being delivered.

Staff respected people's confidentiality, privacy and dignity.

Staff were aware of people's methods of communication and showed regard for people's individuality. People were encouraged to retain their independence.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised to each individual. They contained sufficient detailed information to assist staff to provide care in a manner that was safe and respected people's wishes. Care was delivered in a person centred way, based on people's choices and preferences.

The service had a good programme of activities for people to enjoy which were provided individually or in groups.

Summary of findings

Robust systems were in place to manage any concerns or complaints.

Is the service well-led?

Good

The service was well led.

There were effective systems in place for good governance, quality assurance and safe care for people at the service.

The service's management demonstrated good leadership. There was an open culture and people were encouraged and enabled to have a say in the way the service was run.

Records were well maintained, although some were still in the process of being updated to reflect the new Care Trust as a provider.

Notifications had been sent to CQC or other agencies as required by law.

Baytree House

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 was 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 3 and 4 February 2016. The first visit was unannounced, and both visits took place over the afternoon and evening to enable us to meet people coming to the service for care. We looked at the information we held about the service before the inspection visit and the provider completed a Provider Information Record or PIR. This gave us information about the service and improvements they had made since their registration. Following the inspection we contacted three relatives of people staying at the service for the views about Baytree House.

Some of the people staying at the service at the time of the inspection were not able to express themselves verbally about their experiences. We spent time observing the care and support people received, including staff supporting people with their moving and transferring, eating and being given medicines. We spent time with people over a mealtime and throughout the two visits when people were welcoming of this. On the inspection we also spoke with a visiting district nurse, a Trust infection control nurse and four members of staff. We spoke with the staff about their role and the people they were supporting.

We looked at the care plans, records and daily notes for five people with a range of needs, and looked at other policies and procedures in relation to the operation of the service, such as the safeguarding and complaints policies. We looked at three staff files to check that the service was operating a full recruitment procedure, and also looked at their training and supervision records. We looked at the accommodation provided for people and risk assessments for the premises, as well as for individuals receiving care and staff providing it.

Good

Is the service safe?

Our findings

Systems were in place to identify and report concerns about abuse or poor practice. 'Cause for concern' monitoring sheets were available in people's files to enable staff to report concerns, and these were reviewed on each occasion by the registered manager to ensure any necessary actions were taken. This would include making a report to the local authority safeguarding team if appropriate. Staff had received training in how to protect people, and policies, procedures and information was available on the Trusts online system on how to raise concerns. Staff understood what to do to raise a concern and told us they would do so if they were worried. They said they would be happy for a relation of theirs to be cared for at the service as they felt people were well cared for and supported safely. The service had acted promptly to support people where there had been any safeguarding concerns outside of the service. There were also good links with other agencies involved with people's care such as local learning disability services, with some joint reviews taking place. This helped to ensure all agencies involved in supporting people were able to share any information of concern openly.

There were effective systems in place to manage risks to people. People's files contained individual risk assessments, including for the management of long term health conditions, mobility and behaviours that may be challenging. For example one file we looked at contained clear information about the person's risks from choking when eating. We saw this person being supported to eat their meal by a staff member, which was carried out in accordance with the care plan, and the person ate well. Food was provided by the kitchen staff at the appropriate texture to support the person's swallowing needs in accordance with an assessment carried out by the speech and language team. We later spoke with the staff member who had supported the person with their eating. They told us they had seen the person's care plan, understood the risks associated with the person's swallowing and the support they needed. A relative of this person told us they were satisfied the staff understood the person's needs and risks associated with their care.

Risk assessments had been undertaken of the environment and were available for safe working practices. Equipment was serviced and maintained in accordance with the manufacturer's instructions and emergency plans were available for staff, for example in the case of fire or facilities failure. People living at the service were involved in any fire drills and instructions. Fire evacuation plans were in place and updated regularly. The service had a chart to record the needs of all people potentially using the service which could be used in the case of an emergency evacuation. This included such areas as the person's understanding and mobility needs. Discussions about the importance of fire drills had also been undertaken at the most recent resident's meeting on 15 January 2016. One person who was staying at the service told us about what they had to do when the fire bells rang.

Accidents, incidents and 'near misses' were recorded on an online system. This ensured that any incidents were reviewed by the registered manager and senior staff within Torbay and Southern Devon NHS Foundation Trust, and that any patterns or trends were identified in order to prevent a re-occurrence. We saw that where there had been recent medicine errors action had been taken to prevent a re-occurrence. A pharmacist employed by the Trust had analysed what had gone wrong and re-trained staff. Systems ensured that learning from any investigation outcomes was shared with staff. Prompts on the online system also reminded the registered manager of their responsibilities under the 'Duty of Candour' regulations in respect of being open with people about where there had been incidents or errors with people's care.

The service had a risk register which was used to highlight any potential risks for the attention of senior management within the Trust. This was reviewed regularly. Risks within the service that were identified were quickly assessed and addressed by the registered manager. For example while we were at Baytree House it was discovered that an alarm call bell was not working properly. Measures were immediately put in place to address the risks of sleep in staff not hearing the bell, and the bell was repaired later that day.

People were protected because the service had followed a full recruitment procedure when appointing new staff. We looked at three staff files, which showed us that references and employment histories had been obtained, and disclosure and barring service (police) checks had been carried out. The registered manager was supported in the recruitment of new staff by the systems and support staff from within the Trust. Some staff members had been

Good

Is the service safe?

recruited on fixed term contracts as the long term future of the service was uncertain. The Trust had policies in place for staff disciplinary and grievance processes, and for performance management issues.

There were enough staff on duty to support people's needs. Staffing levels changed to reflect the needs of the people using the service that day. The service used some regular bank staff, some of whom were familiar with people using the service from other learning disability services within the Trust. The registered manager told us the service had a rolling rota for core and senior staff with additional staff to support people with more complex needs, such as moving and positioning in place as needed. Some people using the service had a need for specialist care, for example with complex epilepsy, management of diabetes or feeding systems. This care was given under the delegated authority of the district nursing or hospital teams, and managed under the supervision of a specialist nurse. They ensured staff at Baytree House had the skills to support the person. Staff training in these areas was updated every three months, but if staff were not available with these skills then the district nursing service would be called in to support the person. During our inspection a district nurse visited to support a person with their diabetes management.

Safe systems were in place for the management of medicines. When people came to the service for respite care their medicines were checked in by two staff. No medicines were held in stock by the service. Where people came in regularly their medicines were checked against and recorded on charts which were audited by the Trust. Any changes to people's medicines since their last visit would be verified in a telephone call to the person's GP. For any new people a new medicines administration record (MAR) would be completed. Only senior staff would deal with medicines and staff had received training to do this. Medicines were administered by two people to reduce the risks of errors. No-one using the service was able to manage their own medicines at the time of the inspection. The registered manager told us people had done so in the past and could do if they were assessed as safe to do so.

Medicines were being stored safely. The service's medicines refrigerator was running at a temperature above the recommended level for the safe storage of medicines, but this was being replaced on the inspection visit. No medicines were stored in this at the time of the inspection.

Medicines were being administered safely. We saw people being given their medicines by staff, with people being given time to take them at their own pace, when they wanted and an explanation of what they were taking. For example one person was supported to use inhalers to manage a chest condition. The staff member supporting them told us the person liked their inhalers after their meal rather than before, which was when they had them. Protocols and administration guidelines were in place for emergency medicines for example to support people with epilepsy. There were regular audits of the medicine systems in place, and actions taken to strengthen systems when errors had been highlighted.

At the time of the inspection the service was also receiving an internal audit by the Trust's infection control team. They carried out a full audit of the premises and confirmed that they had identified only minor issues in relation to the management of infection, such as a cracked basin in a bathroom and a replacement toilet frame needed. All areas of the service we saw were clean, warm and comfortable. People needing to use a hoist for moving and positioning bought their own slings into the service, and any specific infection control needs were identified. Staff wore gloves and aprons when delivering individual care and the service's washing machines were capable of achieving a sluicing cycle to reduce any risks of infection from soiled items. Any infection control risks were identified and risk assessments undertaken with actions to reduce the risks.

Good

Is the service effective?

Our findings

Staff had received the training they needed to carry out their role. The service's training records demonstrated that staff received core and specific training to meet the identified needs of people, such as moving and positioning. Some training was delivered online, and staff were notified that updates were needed to their training when it was due. Staff told us they received the training they needed, and several were keen to learn more and develop their skills, for example in learning disability and dementia. Two staff were undertaking longer term training in sign language and another staff member was undertaking a course in palliative care as that was an interest of theirs. Staff also confirmed that they received regular supervision and appraisal. Records demonstrated this covered areas such as staff performance as well as any workplace issues or learning needs. Staff told us they felt supported in their role.

There was recognition that staff had many skills beyond those they had been trained in that were relevant to their working role at the service. For example one member of staff was a skilled craft worker, and they were being encouraged to use these skills to support people with activities.

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.

We checked whether the service was working within the principles of the MCA. We found there was a clear understanding of the MCA in practice with regard to people lacking capacity. Many people who used the service had the capacity to make their own day to day decisions, for example about what they wanted to do each day. Sometimes people needed support to express their wishes or staff needed to understand the person's communication to support them to do this. We saw this working in practice, with people being supported to make choices, for example about what they ate. However, where there was any doubt about a person's capacity, assessments to ascertain or clarify their capacity had been completed. Where care was delivered in people's 'best interests' because they could not express their wishes this was recorded. For example one person had an epilepsy monitor in their room. They had been assessed as not being able to consent to this being in place. Following consultations with their relation and medical services an epilepsy alarm had been put in place to alert staff to the person having a seizure. We did not identify any actions being carried out that were unduly restrictive or not in people's best interests.

People can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager told us no applications for authorisations had been needed for people using the service, and we did not identify any were needed.

People received food and drink that met their choices and needs and supported their health and well-being. Where people needed support to eat this was given sensitively and in ways that supported people's dignity. Menus were changed regularly and the chef on duty was informed by the registered manager what meals would be needed that evening and of any special dietary needs. This included specific textures, such as pureed or 'fork mashable' diets and any other considerations such as low sugar meals needed. People discussed the foods they enjoyed at resident's meetings. At the last resident's meeting this had included curry, fish and chips and ham sandwiches and chips. The menus were being updated to reflect this. The chef told us that if someone didn't like the meal on offer then they would cook them something else. Staff ate with people as part of a social occasion.

People received the healthcare and support they needed from community healthcare services. For most people who only stayed at the service for a short period this was not necessary other than for emergency care or to support the services staff with specialist skills. However some people had been at the service for a longer period until a safe placement could be identified for them in the community. These people had been supported to use community health services including well person clinics, annual health checks and services such as podiatry, opticians and dentists. Healthcare staff told us they did not have any concerns about the service.

Baytree House is a converted period property. The service is long established but presents some environmental

Good

Is the service effective?

issues for the more complex needs of people now using the service. Some changes had been made to the environment to reflect the increased needs of people, with some rooms having had overhead hoists installed and specialist bathing facilities. However not all rooms would be suitable for people with mobility problems. The environment was being assessed for suitability for people who were wheelchair users or who had physical disabilities. Some environmental adaptation was made to meet the needs of individuals at the service. For example one person liked their room to be clear of furnishings so this was arranged for them before they arrived. Other people chose to book their favourite themed rooms in advance, such as a sporting themed room. At the time of the inspection visits the registered manager told us there were nine people who had a sensory impairment who used the service at various times. Whilst there was some provision for sensory equipment there was not significant environmental adaptation for people with sensory impairments.

We recommend the service seek specialist advice on the provision of environmental adaptation to meet the needs of people with sensory impairments.

Good

Is the service caring?

Our findings

We saw many examples of caring relationships at the service. We saw people seeking out staff for support and help. Some people instigated appropriate and affectionate physical contact with staff, such as clasping their hand or placing their head on a staff member's shoulder. We saw people engaging in gentle banter and teasing with staff, and there were positive engagements and laughter in evidence. People were clearly relaxed in the company of the staff. Staff had guidance on managing inappropriate physical contacts from people to ensure clear boundaries were maintained. One person told us "I like it here. I do" and a relative told us "I know (person's name) is happy to come to Baytree House because on the morning of them coming here they are so happy". Another relative told us it was a "home from home" for their relation.

One person was unwell while we were at the service. We saw staff supported them and made them comfortable in a quiet area of the service. They responded to their requests to stay at the service rather than spend time at another placement which had been planned. Staff were attentive, affectionate and caring towards them.

We saw staff sat with people and encouraged them to join in conversations. Staff understood people's communication where this was not verbal. They were able to interpret people's communication through their behaviour or vocalisation. For example we asked a staff member about one person's communication needs and how they would know if they did not want to do something. The staff member could demonstrate to us physically how the person would refuse care and also how another person would communicate their anxiety. People's files contained communication plans detailing how the person showed they were happy, sad, bored, angry, in pain or wanted something.

Staff supported people's dignity and treated them with respect. People were supported to express themselves through their dress and personal style. People's care needs were discussed respectfully and records were written in ways that demonstrated regard for the person. Care was delivered in private and people could spend time in their rooms at any time if they wanted some quieter time.

Private information about people was treated confidentially. Staff did not discuss people's needs in front of other people and spoke quietly and discreetly with people when asking if they needed to use the toilet before their evening meal.

People were given information about the service and encouraged to have a say in making positive changes at the service. Information about Baytree House was available in the 'Baytree Bugle', which was a newsletter sent to people telling them about changes to the service and activities taking place. There was also a guide to Baytree House, "All about Baytree" written in an easy read style with photographs to help people understand what they could expect from the service.

People using the service had elected a person who used the service to represent them and their collective views to the staff and management. This person attended meetings such as the staff meeting with an agenda from people who used the service to discuss areas of concern or interest to them.

The Trust had policies on equality and diversity available, and training was being delivered to staff on the day of the second inspection visit in valuing equality and diversity in the workplace.

Good

Is the service responsive?

Our findings

Each person using the service had an up to date assessment of their needs. This was then used to develop a plan of care to meet the person's needs. Relatives told us they had been involved in drawing up care plans to support their relation in making their needs known where they were not able to do so themselves. Staff understood and followed the plans, which were regularly updated on each admission or where changes were noticed.

Care plans at Baytree House reflected the fact that this was for most people not their main residence or care provider. In that respect they were not always long term goal focussed, but aimed at keeping the person safe and maintaining their care needs for the short time they were at the service. However plans were detailed enough to ensure people's needs could be understood and met. People were encouraged to retain skills they used at home and maintain their independence while at Baytree House. This meant the service had to work closely with families to ensure they understood people's routines and what areas of care people were able to undertake for themselves. We saw this happened with clear plans detailing people's preferred routines in place. Care plans contained photographs for example where people had complex positioning or moving needs to help make sure staff understood how the person was to be supported. Specialist advice was gained from staff within the Trust if needed to ensure this was kept up to date.

Each person also had a diary which they took with them between care settings, such as day service and at Baytree House. This gave information to carers in other settings about what the person had been doing that day if they were not able to communicate the information themselves. This meant for example that if the person had been very active at the day centre, staff would understand that they might like a quieter evening at Baytree. Care plans also covered areas such as people's religious needs or beliefs where known.

People were encouraged to make choices about their care and discuss what they wanted to do in the evening. A staff member showed us photographs of recent activities at the service which people had enjoyed. People chose to have a pampering evening and two people wanted to go to the pub and for a walk. Staff were aware of people's interests and used these to engage and interact with people. For people who were living at the service longer term arrangements were in place to help them move on to a more permanent and settled environment. The process of transition to a new service was undertaken at a pace appropriate to the person's needs and ensured they felt fully comfortable there before decisions were made. This for one person had included spending longer periods of time at their permanent placement to identify if it was the right place for them.

Systems were in place to manage complaints. People's relatives knew how to raise concerns or complaints, but it was acknowledged that some people using the service would not be able to raise concerns verbally. A complaints procedure was available in a picture format to support people's understanding. The registered manager told us that staff were very 'clued in' to people's behaviours and body language and felt they would know if something was wrong. There were notices in the entrance and around the service inviting comments or concerns. Systems were in place to ensure any complaints would be investigated and responded to. No formal complaints had been received about the service. Relatives told us they had only ever had the odd issue to complain about such as missing socks or dirty clothing not always being folded before being returned with their relation.

Good

Is the service well-led?

Our findings

The registered manager of Baytree House had been in post for many years under previously registered providers. They were supported by a senior team and had access to external advice from the Trust in relation to management systems in place. People understood who was 'in charge' at the service, and knew who to go to, to get their needs met. There were clear lines of delegated authority and decision making and staff had access to senior people at all times in case of emergency or needing advice.

Staff told us the registered manager was a good leader. They told us the registered manager was "very good-very approachable", "Clear about what needs to be done" and that they "lead staff well and are on top of everyone's care". They told us they demonstrated good leadership and trusted them to listen to any concerns they had and act upon them. Relatives expressed confidence in their leadership and in the staff team overall.

The registered manager was keen to develop the service. They were using sources of best practice advice, such as the "Outstanding Manager" online forums and were doing a level 5 Diploma in care. They had assessed the service against the standards used by the Care Quality Commission (CQC) to assess the quality of the service and felt confident the service was meeting them. Information about the CQC inspection process had been shared with staff who were encouraged to challenge practices at the service or make suggestions for improvements. Regular staff meetings were held, the last being in January 2016.

The service had an open culture. Staff felt their views were respected and relatives of people using the service understood what they could expect from the service and what to do if they had concerns. There was a clear understanding of person centred care and of respect towards people as individuals. The service's statement of purpose was updated regularly to reflect changes.

The registered manager carried out regular audits of practice such as medicines and environmental assessments to ensure standards were maintained. Other audits were undertaken by the Trust, such as the infection control audit carried out during the inspection. Money had been raised for the service's comforts fund, which had been used to host a party at Christmas. Photographs of this event were being discussed on the inspection, and the accounts of this fund were audited to ensure the money had been spent in accordance with people's wishes.

People were consulted upon about their experiences of the service. There was an annual "Mapping of Excellence" process undertaken when people were sent questionnaires about the service. These were also sent to staff for their perspective on what was working well and what could be improved. As a result of the consultation the service made changes, for example a tablet computer was purchased for use of people staying at the service.

Records were well maintained. Policies and procedures had not yet all been updated to reflect the new Trust, but were being worked through to ensure appropriate governance and ownership. Records seen reflected people's needs and risks associated with their care. They were used by staff who understood their importance and were stored and managed securely. Facilities for the secure destruction of personal information onsite were available.

The service had notified the CQC of incidents or other occurrences as required by law, and were acting within their registration.