Parkcare Homes (No.2) Limited

Bannister Farm Cottage

Inspection report

220 Longmeanygate
Midge Hall
Leyland
Lancashire
PR26 7TB

Website: www.craegmoor.co.uk

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11 December 2017
12 December 2017

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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

Summary of findings

Overall summary

This inspection took place on the 7, 11 & 12 December 2017.

Our last inspection of the home was carried out in July 2015. At that inspection we rated the service as good. At this inspection in December 2017 we found the service remained good.

Bannister Farm Cottage provides accommodation for up to five people between the ages of 18-65 with learning disabilities and autism. The home was fully occupied at the time of our inspection with one person coming to the service daily, Monday to Friday, and staying overnight on one of those days. Bannister Farm Cottage is situated in the Longmeanygate area of Leyland, Lancashire and is in a quiet semi-rural area. Accommodation compromises of three en-suite bedrooms within the main house with two self-contained annexes attached to the house.

Bannister Farm Cottage is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

There was a registered manager in place at the time of our inspection. 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.

The service had systems in place to record safeguarding concerns, accidents and incidents and take necessary action as required. Staff had received safeguarding training and understood their responsibilities to report unsafe care or abusive practices.

Risk assessments had been developed to minimise the potential risk of harm to people during the delivery of their care. These had been kept under review and were relevant to the care provided.

Staff had been recruited safely, appropriately trained and supported. They had skills, knowledge and experience required to support people with their care and social needs.

Medication procedures observed protected people from unsafe management of their medicines. People

received their medicines as prescribed and when needed and appropriate records had been completed.

Staffing levels were seen to be sufficient to meet the assessed needs of the people at the home. Staffing had been highlighted by relatives and staff as an issue prior to our inspection but we saw evidence to show that these issues had been resolved. The reasons for the staffing difficulties experienced were discussed with the registered manager and area manager and were out of the control of the service.

We looked around the building and found it had been maintained, was clean and hygienic and a safe place for people to live.

The design of the building and facilities provided were appropriate for the care and support provided and were being further adapted and improved.

Staff we spoke with had a good understanding of protecting and respecting people's human rights.

The service had information with regards to support from an external advocate should this be required by them.

Various methods of communication were used with people according to their needs and preferences. Some staff we spoke with were not as aware of some people's needs as we would expect. However via the new care planning process we saw that this was being addressed and all staff would be briefed accordingly.

We saw a large range of activities were undertaken both within the home setting and externally and that they were appropriately risk assessed.

The management of the service had dealt with the staffing issues experienced earlier in the year. This had led to staffing levels becoming more stable and areas for improvement had been identified and were already in the process of being completed, for example the care and support planning process.

A number of audits were undertaken to ensure the ongoing quality of the service was monitored appropriately and lessons were learned from issues that occurred.

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 remains safe.	**Good**
Is the service effective? The service remains effective.	**Good**
Is the service caring? The service remains good.	**Good**
Is the service responsive? The service remains responsive.	**Good**
Is the service well-led? The service remains well-led.	**Good**

Bannister Farm Cottage

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 checked 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 7, 11 and 12 December 2017 and was unannounced so the home did not know we were coming to undertake an inspection.

The inspection was completed by two adult social care inspectors one of whom was the lead inspector for the service.

Prior to the inspection the lead inspector gathered the available information from Care Quality Commission (CQC) systems to help plan the inspection. This included the detail of any notifications received, any safeguarding alerts made to the Local Authority, any complaints or whistle-blowing information received and the detail of the Provider Information Return received from the provider. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We were unable to speak directly with any of the people living at the home during our inspection but we did observe staff interactions and spoke with three relatives of people living at Bannister Farm Cottage. We spoke with eight staff including the registered manager, deputy manager, area manager and care staff.

We reviewed all five care records, which were in the process of being re-written during our inspection, with one care record having been completed prior to the inspection. The remaining care plans had been re-written shortly following the inspection and we received confirmation of this from the service. We also reviewed four staff files, training records and records relating to the management of the home including quality audits and monitoring information.

Good

Is the service safe?

Our findings

The home continued to provide a safe service to people. We were unable to speak to people living at the home however we were able to observe staff interactions and speak with relatives. Relatives we spoke with had no concerns about the safety of their loved ones at Bannister Farm Cottage. One relative told us, "I feel [Name] is safe" and another relative said, "I do feel (Name) is safe, I don't have those worries."

The home had an up to date and relevant safeguarding policy and procedure in place. We spoke with staff about the home's safeguarding procedures to ensure they understood them. They were all aware of the safeguarding policy and how to report any potential allegations of abuse or concerns raised and were aware of the procedures to follow. They were also able to tell us who they would report issues to outside of the service if they felt that appropriate action was not being taken and displayed good knowledge of local safeguarding protocols. The home had a safeguarding file in place which recorded any referrals made and any actions taken as a result which evidenced that the home learnt from issues. We saw that appropriate safeguarding referrals had been made to the Local Authority and notifications made to the Care Quality Commission when needed.

At the time of our inspection we saw evidence that staffing levels were in place to meet the needs of the five people who lived at Bannister Farm Cottage. However both staff and relatives did tell us that staffing levels had been an issue within the previous 12 month period prior to our inspection. There had been a high number of staff, (fourteen) leave within a short time frame that had coincided with the previous registered manager leaving. The registered manager told us that there had been 17 vacancies at one point earlier in the year. All staff who had left had worked their notice and given positive reasons for leaving, i.e. a new service had opened locally that they saw as an opportunity for career progression. Exit interviews had taken place to affirm this. This had created staffing issues and the consistency of staff had been an issue given the assessed needs of the people living at the home and the need for a consistent approach to their care and support.

At the time of our inspection however staffing levels were settled and only three vacancies remained. This meant that the use of agency staff was limited and for the two months previous to our inspection vacancies had been covered via the existing staff team and small amount of bank staff, which in turn meant that consistency for people and them seeing the same staff had improved greatly. This had been a concern for relatives but they were now beginning to see the positive benefits of a stable staff team. One relative we spoke with told us, "Staffing has been an issue, when really good staff leave it is upsetting for us and especially for (Name). It has got better of late but it was a concern for good while." We reviewed staff rotas which showed staffing levels had improved in terms of the number of permanent staff and how consistently they were deployed.

We looked around the home and found it was clean, tidy and maintained. Staff had received infection control training and understood their responsibilities in relation to infection control and hygiene. Staff told us they had appropriate personal protective clothing such as disposable gloves and aprons. Hand sanitising gel and hand washing facilities were available to staff. This meant staff were protecting people who lived in

the home and themselves from potential infection when delivering personal care and undertaking cleaning duties. Suitable arrangements were in place for the disposal of clinical waste and for handling COSHH (Control of Substances Hazardous to Health) equipment.

As at the previous inspection appropriate procedures were in place, and followed, with regard to the recruitment of staff. We reviewed four staff files and found the necessary background checks had been carried out and that the home's recruitment policy and process had been followed. The process included matching staff to people, and relatives and advocates were included in the recruitment process when possible. Disciplinary procedures were in place and we saw evidence of them being followed.

Medication care plans and risk assessments provided staff with a good understanding about specific requirements of each person who lived at Bannister Farm Cottage, including side effects and protocols. Staff had relevant training and competency testing to assist them in the safe administration of medicines. We did find some prescription details missing on some of the Medication Administration Records (MAR's) and some protocols not having changed as medicines were reviewed. We also discussed the appropriateness of the room used for the storage of medicines as it was very small and warm. We were told this was to be reviewed and that a different location was to be considered.

We looked at how accidents and incidents were being managed at the home. We saw that many of the incidents were behavioural issues and that these were recorded comprehensively. Staff who had been involved in incidents were restraint was used were debriefed and the incident was fully reviewed. We did find some incidents had not been signed off by the staff member involved. This was an area we discussed with the registered manager to ensure that evidence was in place to so that staff were fully supported throughout the process. All accidents and incidents were recorded and themes and trends were beginning to be explored to help prevent similar issues going forward.

Care plans we looked at contained completed risk assessments to identify potential risk of accidents and harm to staff and people in their care. Care plans and associated documentation was being reviewed at the time of our inspection. By the end of the inspection process we saw that two care plans, with appropriate documentation, had been fully reviewed. These contained up to date information to fully reflect people's care and support needs. We received confirmation shortly after the inspection that all five care plans were fully updated. Risk assessments within the up to date care plans were reflective of people's care, support and daily living. Some of the previous risk assessments seen were in need of being updated however this was done shortly following our inspection and we were sent evidence to confirm this.

We saw that the service learnt from previous experiences and issues. One example of this was how the layout of one person's room had been changed so staff could access their medicines without disturbing them. This was particularly important as this person could display behaviour which prevented staff from accessing the room were medicines were stored. By changing the layout of the room this meant staff could bypass the main living area and access medicines and prepare them without further agitating this person.

Good

Is the service effective?

Our findings

Relatives told us that the current staff team were knowledgeable about their loved one's care needs and they were satisfied they were being met. Again references were made to the staffing difficulties previously however this then led onto more positive comments on how the current staff team worked with their loved ones. One relative told us, "When the dynamics of the house changed (due to staff leaving) this had an effect on (Name). I am now beginning to get confidence in the new team." Another relative said, "I feel more confident now and hope things continue to improve."

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that capacity assessments and best interest decisions were decision specific and contained a good level of information. Staff we spoke with were knowledgeable and had received recent training in this area.

As at the previous inspection staff were supported well, this included regular supervisions, annual appraisals and training to deliver their roles effectively. Staff we spoke with did tell us that a few months previous to our inspection, due to issues with staffing numbers, that the support they received was not as robust as it could have been but that this had now improved as staffing numbers had become more settled. Specialist training was given to staff given the assessed needs of the people living at Bannister Farm Cottage, for example 'Positive Behavioural Support (PBS) and 'Proact Skip'. 'Proact Skip' is a training package designed for staff who support individuals who may from time to time demonstrate behaviours of concern. We did discuss with the registered manager the need for more autism specific training for staff although we recognised that elements of staff induction and other training did touch upon this area.

We did not see any evidence of restraint being used without reason and saw some good examples of how the service could reduce the use of restraint. One example was for one person who has historically been restrained when travelling. The home were reviewing this practice and looking at alternative ways of managing and reassuring the person whilst using the home's transport.

The home is newly built and adapted to meet the assessed needs of the people at Bannister Farm Cottage. We also saw some good examples of recent and ongoing changes to suit the individual needs of people including the moving of doors to enable the ease of access to different areas for one person and the staff

that supported them. We discussed the environment of one person's room as it appeared bleak. There were reasons as to why this particular person's room was sparsely decorated but we discussed methods such as the projection of images onto walls and access to soft play items to improve the environment whilst keeping the person safe.

People were supported to have their nutritional and hydration needs met. This included information within the home of people's preferences and dietary needs. Care plans reflected people's needs in this area and we saw that referrals had been made to appropriate professionals such as dieticians and the speech and language therapy team.

Prior to admission to the home the service had completed a full assessment of people's individual needs and produced a plan of care to ensure those needs were met. We saw evidence they or a family member had been involved with and were at the centre of developing their care plans and that they were reviewed at regular intervals. The review process had been delayed during the previous 12 month period to our inspection due to the service having to prioritise and focus on staffing issues. These issues had however been resolved and reviews had been completed on all care plans by the time the full inspection process had been completed.

When we spoke with relatives and staff we were told that communication within the home was good. As with a number of areas the staffing issues experienced during the summer months of 2017 meant that there had been issues previously in this area. However we saw a number of systems in place including care reviews, team meetings and memos that meant relatives and staff were kept up to date with current issues and developments for individuals and across the service.

Good

Is the service caring?

Our findings

We observed positive interactions throughout the inspection visit between staff and people who lived at the home. We saw that people were relaxed in the company of staff and it was evident that staff knew the people they cared for. Relatives we spoke with had no concerns but again mentioned the issues with staffing levels and consistency when asked about how they felt staff approached their caring role. One relative told us, "The changes of staff have been a worry, (Name) gets to know staff and then they move on. I have however more confidence now and staffing does seem to have settled down." Another relative said, "I don't have major concerns in this area but there has been a lot of toing and froing with staff. Staff consistency has been my main concern going back a few months."

Staff we spoke with had a good understanding of protecting and respecting people's human rights. They were able to describe the importance of respecting each person as an individual and spoke well and knowledgeably about people's privacy and dignity as well as how to maintain confidentiality.

We saw people and their relatives or advocates had an input into how their care and support was designed. This included being part of the review process. The registered manager had introduced a monthly invitation to relatives so they could sit down and go through their loved ones care plan in detail to ensure it was reflective of their currents needs. This helped to create a person centred picture of the person which benefitted staff in knowing how to care for people effectively.

Communication had been raised as an issue historically with some of the relatives we spoke with however they told us this had now improved. We saw various methods of communication used including monthly care reviews as mentioned above, face to face meetings, telephone conversations and feedback forms for relatives to use if they did not wish to discuss them verbally.

We saw various methods of communication in use with people such as the use of 'I-pads; 'etcher sketch' and PECS (Pictorial Exchange Communication System). PECS allows people with little or no communication abilities to communicate using pictures. However we did have discussions with staff about the best way to communicate with people and there were some differences of opinion in the best methods to use. We discussed this with the registered manager and people's preferred communication methods were reinforced to staff and people's new care plans reflected their needs in this area appropriately within the section; 'How I communicate and how you should respond'. Therefore not only were people's own communication methods clear but also how the staff that supported them were expected to communicate back to people. Clear protocols were in place from Speech and Language assessments, on the use of PECS and any other visual communication methods used.

If people did not have support from family then they had access to formal advocacy support. One person at the home had support from an Independent Mental Capacity Advocate (IMCA). The IMCA had no concerns with how the service was supporting this person when we contacted them. The service had information details for people and their families if this was needed with regards to the different types of formal support they could be entitled to if needed. This ensured people's interests would be represented and they could

access appropriate services outside of the service to act on their behalf if required.

Good

Is the service responsive?

Our findings

We reviewed all five care plans at the home during the two days of our inspection. In all the care plans we reviewed, both previous versions and the newer version, we found lots of good person centred information about individuals, their histories and how to provide their support. Two people's care plans had been fully transferred to the new version by the time our on-site inspection had finished. We later received evidence to show that the remaining three care plans had been transferred to the new version. We were confident that these new care plans reflected people's most up to date needs and provided staff with the information they needed to carry out their roles effectively.

During our inspection we did review older versions of care plans, which were still in use at the time, and found them to be too large and cumbersome for staff to find them to be a fully effective tool. This had resulted in some information being contradictory as it was difficult to replicate information across the different areas of support plans consistently and some of the information was out of date. We did accept that as the service had experienced major issues with the loss of staff earlier in the year that the recruitment of both temporary and permanent staff had to be the priority for the service and that this issue was well on the way to being resolved. Also the fact that two care plans had been fully revised, slimmed down and that monthly reviews were set up with families to gain their regular input meant that the service had already recognised that care and support plans were their next priority. None of the issues we raised with the care plans in their previous format were ones that had not been recognised, and were well on the way to being rectified, by the service. Indeed only a couple of weeks later all care plans had been transferred to the new version.

Staff we spoke with who had seen the new care plan format told us they found them much more useful than the previous versions which were difficult to navigate. This meant that they could work more efficiently as they could reference information and guidance much more quickly due to them being concise and consistent throughout. We were assured that staff, as well as relatives, would have a greater input into care plans reviews going forward.

The service had a complaints procedure which was made available to people via the service users guide. We asked that the policy be put on display in the home, although we accepted that as the service was small and homely that they did try to limit all but the most essential 'corporate' displays. The procedure was clear in explaining how a complaint should be made and reassured people these would be responded to appropriately. Contact details for external organisations including social services and the Local Government Ombudsman had been provided should people wish to refer their concerns to those organisations. Relatives we spoke with told us they knew how to raise complaints or issues with the service and were able to speak with the registered manager or deputy manager easily.

We saw that people were given choices and that this was recorded within their care and support plans. Information was pertinent to individuals, for example people had one page profiles detailing their preferences as well as dislikes and there were other sections within peoples care plans such as 'My month in pictures' which detailed people's preferred activities. There were many more examples seen.

We saw a large range of activities were undertaken both within the home setting and externally. There was evidence to show that comprehensive risk assessments were carried out prior to any activities taking place and that staff were aware of them. Some examples of activities we saw were swimming, walking in the local area, eating out and attending parties and events. Some of the relatives we spoke with felt that there had been issues with a lack of activities as a result of staffing issues earlier in the year but that these were beginning to be resolved and a more regular programme of activities were being undertaken.

End of life care was an area that needed to be further explored at the service. Given that the people living at Bannister Farm Cottage were young, it was understandable that this was not an area of prioritisation. However we were told that this would be explored going forward and discussed, as appropriate, with people and their relatives or advocates so the service knew what people's preferences were at the end of life in advance.

Good

Is the service well-led?

Our findings

A registered manager was in place who was also in the process of applying to be registered at another service within the organisation. 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. Both the registered manager and deputy manager shared their time at Bannister Farm Cottage and a neighbouring service within the Priory group. We were told by both that they felt that sharing their time between the two services did not have a detrimental effect on either service and that one of them was on site and/or available for staff or relatives to contact.

Relative's comments were, as highlighted within the other domains in this report, a mixture of positive comments on more recent times and negativity towards how they felt the service had been managed earlier in the year. We accepted that due to the set of circumstances that led to a large amount of staff leaving the service that this had an inevitable negative impact on how the service was able to run efficiently at the time. However some comments from relatives indicated that they felt the communication to them by the management team could have been better handled at the time. One relative told us, "I think communication can be reactive at times." Another relative said, "Information needs to be more consistent, communication is improving but there is still more to do." All the relatives we spoke with told us that they felt they could approach the management team, or any staff members with their issues and felt comfortable doing so.

The service had procedures in place to monitor the quality of the service provided. Regular audits had been completed. These included reviewing the services medication procedures, care plans, infection control and environment. Senior managers from the wider organisation carried out external audits and mock inspections of the service and action plans were devised as a result.

The registered manager had introduced a number of initiatives to improve staff morale, this included an employee of the month award, were successful staff won £25, a staff suggestion scheme and access to funding for specialist training. The registered manager was also looking at creating a specialist night team following feedback from staff that they struggled to work across days and nights, this showed that the management team listened to feedback from staff.

The service worked in partnership with other organisations to make sure they were following current practice, providing a quality service and the people in their care were safe. These included social services and healthcare professionals including General Practitioners. The service also worked closely with Independent Mental Capacity Advocates (IMCAs). IMCAs represent people subject to a DoLS authorisation where there is no one independent of the service, such as a family member or friend to represent them.

The service had on display in the home their last CQC rating, where people who visited the home could see it. This has been a legal requirement from 01 April 2015. Notifications were sent into the CQC as needed and all other registration requirements were evidenced to be met.