Care Quality Commission

Supreme Care Services Limited

Fir Trees House

Inspection report

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Ratings

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

Overall summary

Fir Trees House is a care home providing accommodation and personal care for up to seven people with learning disabilities or mental health support needs. There were five people living at the home at the time of our inspection.

The inspection took place on 1 October 2015 and was unannounced.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risk assessments for people were not regularly reviewed to ensure staff had the most up to date information. Staff told us they were unsure as to how to support someone in the community which meant their opportunities were limited.

Summary of findings

There were sufficient staff deployed in the home. Staffing numbers were flexible to ensure people's individual needs were met. There were enough staff to enable people to go out and to support the people who remained at home.

Staff had a clear understanding of how to safeguard people and knew what steps they should take if they suspected abuse. There was an effective recruitment process that was followed which helped ensure that only suitable staff were employed.

Medicines were managed well and risk assessments were in place to mitigate the risk of mistakes being made. People were supported to maintain good health and had regular access to a range of healthcare professionals.

Staff did not have a good understanding of the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. This meant that decisions made may not always be taken in the persons best interests.

People were involved in choosing what they had to eat and drink and menus were displayed.

Staff received training and supervision to enable them to have the necessary skills to carry out their role. Training was regularly reviewed to ensure staff had the most up to date information.

People interacted with staff in a positive and friendly manner. However, interaction from staff was not always respectful. People were supported by staff who knew people well and respected their privacy. Visitors were welcomed to the home.

People were not supported to develop independent living skills. Care plans did not detail progress for people who wanted to move on to more independent living. People's needs were assessed prior them to moving into the service but plans were not regularly updated meaning staff did not always have the most up to date information when supporting people.

There was a complaints policy in place which was displayed in an easy read format. Relatives told us they knew how to make a complaint should they have any concerns.

Audits completed by the service did not always identify shortfalls in service delivery and actions to rectify issues were not always recorded. Audits showed that records had been reviewed but did not check the quality of the information presented.

Accidents and incidents were reviewed by the manager to reduce the risk of incidents happening again. A contingency plan was in place to ensure that people's care could be provided safely in the event that the building could not be used.

During the inspection we found some breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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?

Requires improvement

The service was not always safe.

Risks to people were not consistently identified and control measures were not always implemented to protect people from avoidable harm.

Medicines were stored and administered safely.

There were sufficient staff deployed to meet people's individual needs.

Staff were aware of the different types of abuse and how they should report any concerns. Safe recruitment processes were followed.

People lived in a safe environment. Equipment was regularly checked and relevant risk assessments were in place.

Is the service effective?

Requires improvement

The service was not always effective.

Staff did not have a good understanding of the Mental Capacity Act 2005 Capacity assessments and best interest decisions were not always completed appropriately.

Staff received training and supervision to ensure they had the skills to meet people's needs.

People had a choice about what they had to eat and drink.

People's health care needs were met and relevant health care professionals were involved in people's care.

Is the service caring?

Requires improvement

The service was not always caring.

Interaction from some staff was not always respectful.

People were not always involved in the running and development of the service.

People's privacy was respected.

Visitors and relatives were made to feel welcome.

Is the service responsive?

Requires improvement

The service was not always responsive.

Care plans did not cover all aspects of people's needs.

People had routines in place but would benefit from a more diverse range of activities to meet their needs and preferences.

Summary of findings

Detailed assessments were completed prior to people moving into the service.

Information on how to make a complaint was made available to people and their relatives.

Is the service well-led?

Requires improvement

The service was not always well-led.

Audits did not always identify where improvements were required.

Staff felt able to discuss issues with their manager. Staff told us the registered manager was approachable and supportive.

Accidents and incidents were reviewed to minimise the risks to people.

The manager and staff said they felt supported by the organisation.

Fir Trees 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 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 01 October 2015 and was unannounced. The inspection was carried out by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. On this occasion we did not ask the provider to complete a Provider Information Return (PIR) before our inspection. This was because we inspected the service sooner than we had planned to. 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 asked five people about their experience living at Fir Tree House and observed the care and support provided to them. We spoke to the manager, three staff members and two relatives following the inspection.

We reviewed a range of documents about people's care and how the home was managed. We looked at three care plans, medication administration records, risk assessments, accident and incident records, complaints records, policies and procedures and internal audits that had been completed.

This was the first inspection of the service since it was registered in December 2014.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe living at Fir Tees House. One person said, "I feel safe here, there are always staff around making sure everyone's ok." A relative told us, "There were concerns it wasn't the right place when (name) first moved in but they're stable and happy. There are always enough staff around when I visit."

Despite these comments we found that risks to people's safety were not consistently assessed and guidance was not always provided for staff to enable them to minimise risks. We saw that each person had a screening document in place to identify potential risks to each individual. The manager told us that where risks were identified a comprehensive assessment should be completed. However, we saw that this process had not consistently been followed. For example, records of a keyworker update recorded that one person 'behaved in inappropriate way to other people and even children'. We spoke to a staff member who confirmed the person may shout at small children and be could be verbally abusive to members of the public. There was no risk assessment in place to address these issues and staff were not provided with guidance on how to support the person when in the community. Staff told us the person was often reluctant to go out and often became anxious, they were unsure as to the best way to support them. This meant the persons opportunities to access the community were limited.

One person's risk assessment showed they were at risk as they were prone to falls and visited the local shops unescorted. The registered manager was able to describe the steps which had been taken to reduce the risks to this person although the risk assessment had not been updated and guidance was not available to staff.

Guidance was not available to staff on what support each person required should they need to evacuate the building in an emergency. Personal emergency evacuation plans (PEEPS) had not been completed for people. PEEPS set out the individual requirements of each person to ensure they could be safely evacuated from the service in the event of a fire.

The lack of ensuring people had safe care and treatment was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were enough staff deployed to support people according to their needs and preferences. On the day of the inspection there were 3 staff members available in addition to the registered manager. Documentation showed that these staffing levels were consistently available during the day. Staffing levels ensured people were supported safely within the home and in the community. We spent time observing care in the communal areas and saw there were enough staff on duty to respond promptly to people's requests for assistance. Staffing levels were lower during the evening although where people wanted to go out staffing levels were increased to enable this. One person told us they had been to see a show at a local theatre the previous evening.

People were safeguarded from the risk of abuse. The home had clear safeguarding policies and procedures in place for staff to refer to. Staff were able to explain how they would recognise and report abuse. They told us they would report concerns immediately to their manager or to the police if this was necessary. The service had a whistleblowing policy in place which gave staff clear steps to follow should they need to report poor practice.

Medicines were managed safely. One person told us, "They always remind me when it's time to have my meds." Another person said, "Staff always make sure I get my meds." Each person had a recent photo on their Medication Administration Records (MAR charts) and details of allergies were recorded. Medicines were stored securely and MAR charts showed that medicines had been administered in line with prescriptions. Protocols were in place for the administration of 'as needed' medicines (PRN) which gave staff clear direction.

Regular stock checks were completed and systems were in place for returning unused medicines to the pharmacy. Staff had received training to administer medicines properly and their competency in doing so had been assessed.

Staff recruitment files contained evidence that the provider obtained appropriate information prior to staff starting. This included proof of identity, such as passport or birth certificate, written references and Disclosure and Barring checks. There was evidence that all applicants completed an application form and attend a face-to-face interview before they were appointed. This gave assurances that only suitable staff were employed to work in the home.

Requires improvement

Is the service safe?

All areas of the home were open and there were no restrictions in place. People had a key to their bedroom door and the front door. We were told that the latch to the front door was put on at night but this was done for people's safety and security not to restrict people's movements. Staff were available throughout the night to answer the door so people could gain access.

People lived in a safe environment because checks of the premises and equipment were carried out on a regular basis and any problems were reported through the maintenance system. Records showed that the regular servicing had been undertaken of fire equipment and systems, portable appliances and gas appliance.

A continuity plan was in place which detailed where people could be evacuated to in the event that the building could not be used. This minimised the disruption to people should emergencies occur.

Requires improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides the legal framework to protect and support people who do not have the capacity to make specific decisions. Staff we spoke to were not able to demonstrate their understanding of the MCA or Deprivation of Liberty Safeguards (DoLS). They did not have knowledge of the principles of this or processes to follow. They were not aware of the process to follow when best interest decisions needed to be made. Training records showed that not all staff had completed MCA training although this had been arranged for later in the year.

Mental capacity assessments were not completed regarding specific decisions. We saw one person had paperwork in place which assessed that they did not have capacity to make decisions. However, there was no evidence to show how the person was supported to make day to day decisions or that best interest meetings had taken place regarding individual decisions.

There was evidence that the manager and mental health team had been involved in talking to people in the local community to help make the person safe. However, there was no evidence that the person's mental capacity had been assessed prior to this. This meant that the person's right to make decisions may have been compromised.

Not meeting the requirements of the Mental Capacity Act 2005 is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People's health was monitored and when it was necessary health care professionals were involved to make sure people remained as healthy as possible. Appointments with health care professionals such as doctors, dentists and chiropodists were recorded in care files. There was evidence that health checks were carried out and that changes in health were identified in a timely manner. We saw evidence that the manager worked closely with local mental health teams to monitor people's wellbeing.

People were involved in choosing what they had to eat and drink and told us they enjoyed the food offered. People and staff told us that they planned menu's monthly with them and also checked before each meal that they were happy with the option. We observed staff speaking to people before they started preparing meals and asking them if they had any preferences. A menu plan was in place for each person and the fridge and freezer were well stocked with fresh ingredients.

Staff were inducted into the service and received training to support them in carrying out their role. One staff member, who had recently started work, told us they had received an induction which included learning about people's needs, systems and where everything was kept. They had received all mandatory training prior to starting work. A training plan was in place which included mandatory health and safety training, safeguarding and medication. We saw training records which highlighted when staff had completed training and tracked when they were due to have refresher training.

Records showed that staff received supervision sessions every two months and underwent an annual appraisal. Staff reported they found these useful and notes demonstrated that staff development and designated responsibilities were discussed.

Requires improvement

Is the service caring?

Our findings

People told us that staff were caring and treated them with respect. One person said, "The staff always speak with respect. Very rarely do people come into my room, I like to be left alone and they respect that." Another person told us, "Staff are very nice. They treat you like a normal human being, that's how I like to be treated."

We observed people responded positively to staff and there was a relaxed and friendly atmosphere in the home. However, staff were observed to react in an impatient manner with one person on a number of times during the visit. For example, staff asked the person if they would like to have a shower, the person raised their voice saying they would have one later. The staff member continued to ask the person a further four times despite the person saying they were not ready. The staff member then sighed loudly before walking away and telling another staff member that they would need to try. The staff member did not take the time to find out person did not want a shower. The second staff member offered reassurance about slipping in the shower and a few minutes later the person asked for support with showering

On other occasions throughout the day we saw the staff member interacting well with the person. For example, the person asked for assistance using their ipad, the staff member stayed with them until they were confident in what they were doing.

We also saw records in relation to this person were not always written in a respectful manner. For example, one report recorded, 'can become resentful and unruly if people are getting more attention than (name).' and another stated, 'can be very rude when they want, needs to be corrected with regards to rude behaviour.'

We recommend the provider remind staff in treating people with respect.

People took part in monthly 'residents meetings'. People told us that meetings were held but said that these were mainly about menu's rather than how the home was run. The manager was able to show us handwritten notes of the previous meeting which reflected what activities people had taken part in. People told us that if they wanted something to change they could speak to the manager and they would be listened to.

Staff were able to describe people's needs and preferences and people told us their choices were respected. For example, one person told us they found it difficult to work with one staff member as they reminded them of someone and they had asked not to be supported by them. They told us this request had been honoured and the staff member were still polite when they did meet in communal areas.

The home was decorated and furnished to a high standard. Communal areas were comfortable and homely. However, the upstairs of the property had laminated flooring which one person living in a downstairs room said caused them to be disturbed frequently, "The noise from upstairs really gets me down, it goes on until midnight sometimes." We spent time in the persons room and could hear loud banging and footsteps coming from the room above. The manager said they were not aware of the problem but would look into possible solutions.

People's rooms were personalised and people's privacy was respected. People's room were decorated with photographs and items personal to them. We saw that staff knocked on people's doors and waited for permission before entering people's rooms. People told us that staff always did this.

People were encouraged to maintain relationships with their family and others close to them. People told us they regularly met their family members in the nearby town. People said their family members were made to feel welcome when they visited the service.

Requires improvement

Is the service responsive?

Our findings

One relative told us that they felt communication could be improved, "If I'm concerned about anything I can ask to speak to staff or the manager. It would be nice if they rang to tell me when (relative) had achieved something or done something good rather than just when things go wrong."

People were not always encouraged to develop independent living skills. We observe that staff were focussed on household tasks rather than spending time involving people. During the inspection we saw that staff cleaned the house, unpacked the food delivery and prepared meals. People were not encouraged to be involved in completing these tasks. Care plans did not guide staff in supporting people with daily living tasks and people's skills in this area were not reassessed regularly. One person told us, "The food is always nice, it's the staff who prepare it. The staff write the shopping list and when the food is delivered the staff put it away."

A number of people told us that they hoped to move to more independent accommodation in the future. Care plans we saw did not reflect this and there was no evidence to show how people were encouraged to develop the skills they needed to increase their independence. The manager told us that people were encouraged to complete small tasks such as hoovering the hallway or getting ingredients out of the cupboard for the meal but no structured plan was in place regarding people moving on.

Care plans were handwritten making them difficult to read and did not cover all aspects of people's needs. For example, there was no guidance given to staff regarding one person who spent all of their weekly money on the day they received it meaning they had nothing to spend on activities for the rest of the week. The manager described different strategies which had been tried to support the person although no written guidance was available for staff.

One person's care plan contained no information regarding the person's likes, preferences or dislikes. The plan highlighted the person required prompting with personal hygiene but did not guide staff on how to encourage the person.

The failure to complete care plans reflective of people's needs and preferences was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some areas of people's support gave detailed guidance to staff on how people preferred to be supported. One person's assessment detailed that without a structure in the morning their mental health may start to deteriorate. A plan had been agreed with the person regarding what time they got up, personal care tasks and activities. A copy of the plan was on the person's bedroom wall so they were able to mark off when they had completed each task. The person showed us their plan and said it helped to keep them well.

People's needs were assessed prior to them moving into the service. People were involved in their assessment as much as possible and were supported by a relative or advocate if appropriate. Assessments were completed in detail and covered all aspects of people's care and support needs.

Reviews of people's care were completed on a regular basis. Reports were sent to commissioners on a quarterly basis where requested and contained details of what the person had done and statements regarding their general well-being. Annual reviews were held for each person, there was evidence that where appropriate family members and care managers were invited to attend.

People had set activities they took part in each week. This included visiting relatives and local church groups. Occasional trips to the cinema and local shows were also organised. One person told us they attended a day service during the week which they enjoyed. However, there were few activities available in the service to stimulate people when they were at home. I sometimes get bored, I'd like to do other things." Another person told us, "I talk to staff or watch TV when I'm not going out. It would be good to have things going on." A staff member told us that they thought the service could be improved by having more activities at home for people. "It would be good for people to have more to do, things brought in like the music man."

We recommend the provider looks into whether additional activities specific to people's needs are available.

There was a complaints procedure in place which was clearly displayed. One relative we spoke to said they had

Requires improvement

Is the service responsive?

not had reason to raise a complaint regarding the service but were aware of how to do so and would be comfortable in reporting anything they were concerned about. An easy read version of the complaints procedure was displayed in the hall and a copy was on each person's file. People we spoke to said they would speak to the manager or a relative if they had a complaint and felt their concerns would be listened to.

Requires improvement

Is the service well-led?

Our findings

We saw the manager was accessible for people to talk to. One person told us, "I get on well with the manager, (name) has a great sense of humour." The manager's office was situated adjacent to the lounge and their door was open throughout the visit. People appeared relaxed in going to the office to chat or calling for the manager to speak to them. Discussions were upbeat and reassuring where needed. We saw the manager tried to involve everyone present in conversations.

Audits and checks of the service did not always identify areas requiring improvement. We saw that audits of care files were completed regularly. Although audits highlighted that files had been reviewed they did not check the quality of the care plans, risk assessments and guidelines to ensure staff had the most up to date information. An internal audit of daily records concluded that reports were not always clearly written and did not always convey meaningful information. The action plan did not detail what needed to be changed and did not state how this was to be achieved.

Feedback was sought from people involved in the home although this was not reviewed to make improvements to the service. We saw that satisfaction questionnaires had been completed by family members and professionals in July 2015 and comments were mainly positive. The questionnaires had not been reviewed and comments regarding improvements which could be made had not been actioned.

Records of staff meetings were not available. The registered manager told us that they aimed to hold a staff meeting every two months and staff told us they were held regularly. However, the last meeting minutes available were dated May 2015. This meant that staff unable to attend meetings were not kept up to date on developments and objectives set for the service.

Although residents meetings were held in the service minutes of the meetings were not produced. Evidence of how people were involved in the running of the service was not recorded.

The lack of effective quality assurance systems to ensure good governance was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The audits completed also included checks on cleanliness, medicines and maintenance of the home and where improvements were required these had been completed. The manager and area manager told us that findings from external reports in other homes were shared throughout the organisation to ensure that lessons were learned. We saw evidence that following a medication audit in another home, systems had been reviewed throughout the organisation to ensure best practice was being followed.

There were procedures in place for recording and monitoring incidents and accidents. Records showed where incidents had occurred people had been supported appropriately and where required other agencies had been involved. Incidents had been reviewed and guidance provided to staff to minimise the risk of incidents being repeated. All accident and incident forms were reviewed by a senior manager in the organisation to check that appropriate action had been taken. The manager was aware of their requirements of registration to notify the Care Quality Commission of any important events that happen in the home.

Staff told us there was an open culture within the service and they were able to discuss any problems with the manager and received a response. They told us there was a good team atmosphere and they could rely on each other and the manager for support if there were any problems. One staff member told us the manager was always available, "It makes a good atmosphere." The manager told us they tried to create an open and friendly culture in the home where people had choices and staff could spend tie with people.

The manager told us they felt supported by the organisation, "My manager visits every week and I know I can contact her if I need anything." We spoke to the area manager who knew the service well and observed that people chatted easily with them.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered provider had failed to ensure risks to people safety and well-being were not consistently managed.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered provider failed to ensure staff followed the requirements in line with the Mental Capacity Act 2005.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered provider had failed to ensure systems to identify shortfalls in service provision were identified and action was taken to rectify.**