Care Quality Commission

Living Ambitions Limited

Whitwood Grange

Inspection report

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Ratings

Is the service safe?	Good
Is the service well-led?	Requires improvement

Overall summary

This inspection of Whitwood Grange took place on 7 and 11 December 2015.

We carried out an unannounced comprehensive inspection of this service on 22 and 25 September 2015. After that inspection we received concerns in relation to the management of behaviour that challenges causing injury to staff and people who use the service due to a lack of suitably experienced, trained staff and concerns that staff were not supported appropriately. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Whitwood Grange on our website at www.cqc.org.uk

Whitwood Grange is registered to provide accommodation and personal care for up to 17 people with a learning disability. They provide a service to people with complex needs and behaviours that challenge. The service is divided into three units.

The service 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.

People who lived at Whitwood grange, who were able to do so, told us they felt safe.

Risk assessments minimised risk whilst promoting people's independence

There were enough suitably trained staff to meet the assessed needs of people who used the service.

Staff had a good understanding of safeguarding adults from abuse and who to contact if they suspected any abuse.

The provider had not done all that was reasonably practicable to assess, monitor and mitigate risks to staff. This was a breach of Regulation 17 (2) (b)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Summary of findings

The culture of the service was positive, person centred, open and inclusive and staff spoke positively about the registered manager

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?

Good 

The service was safe

The risk assessments we sampled minimised risk whilst promoting people's independence.

Individual behavioural incidents were analysed to reduce risks

There were enough suitably trained staff to meet the assessed needs of people who used the service.

Staff had a good understanding of safeguarding adults from abuse.

Is the service well-led?

Requires improvement 

The service was not always well led

The provider had not done all that was reasonably practicable to assess, monitor and mitigate risks relating to the health, safety and welfare of staff.

The culture was positive, person centred, open and inclusive.

People spoke positively about the registered manager

The manager sought feedback from staff in order to support them in their role.

Whitwood Grange

Detailed findings

Background to this inspection

We carried out an unannounced comprehensive inspection of this service on 22 and 25 September 2015. After that inspection we received concerns in relation to the management of behaviour that challenges causing injury to staff and people who use the service due to a lack of suitably experienced, trained staff and concerns that staff were not supported appropriately. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Whitwood Grange on our website at www.cqc.org.uk

This inspection of Whitwood Grange took place on 7 and 11 December 2015. The visit on 7 December was unannounced and the visit on 11 December was announced. The inspection team on the first day of the inspection consisted of two adult social care inspectors 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. On this occasion they were a family carer of a person with a learning disability and behaviour that challenges. One adult social care inspector visited on the second day.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider, and feedback from the local authority safeguarding and commissioners.

We had not sent the provider a 'Provider Information Return' (PIR) form prior to the inspection. This form enables the provider to submit in advance information about their service to inform the inspection.

At the time of this inspection there were 16 people living at Whitwood Grange. Some of the people who used the service were unable to communicate verbally and as we were not familiar with everyone's way of communicating we used observation as a means of gauging their experience

We spoke with three people who used the service and one relative, seven members of staff, one deputy manager, the registered manager and the operations manager. We observed how care and support was provided to people. We looked at documents and records that related to people's care, and the management of the home such as incident reports staff recruitment records and staff training records. We looked at three people's care records.

Good

Is the service safe?

Our findings

People we spoke with who were able to do so told us they felt safe. One person who used the service said, "staff help me stay safe". They told us If they felt concerned about safety they would talk with staff. One person said they, "had a laugh with staff", and another said they "get on with all the staff and other residents."

Prior to this inspection we received information of concern that staff were being injured during behavioural incidents and did not feel supported by the service. Staff told us they recorded and reported all accidents and people's individual care records were updated as necessary. We saw in the incident and accident log that incidents and accidents had been recorded and an incident report had been completed for each one and singed by staff and managers. Accidents and incidents were recorded in detail and we saw staff were aware of any escalating concerns and took appropriate action. Incident reports and debriefs covered possible triggers to the incident, whether physical intervention was necessary and a section for staff to discuss how they felt after the incident.

Physical intervention plans we saw for people were detailed and gave guidance to staff on effective and safe approaches. For example before physical intervention, "Distract and use PRN protocol for pain relief." The method of intervention to prevent one person walking into the road was clearly described. The associated risk assessment recorded what was working or not working, a debrief around the incident and any actions to complete following the incident to improve safety. This demonstrated staff were enabled to manage behaviour that challenges others, whilst ensuring people's rights were protected.

We looked at incident reports where staff had been injured during physical intervention. When asked about the number of behavioural incidents where staff had been injured managers told us they felt consistency of approach and treatment for the persons health problem had now reduced injuries to staff during behavioural management incidents.

The majority of staff we spoke with agreed the number of incidents had decreased however one member of staff who had been kicked in the head a number of times during one incident said that the physical intervention training didn't work. They did not feel supported after the incident.

We discussed the number of blows to the head to staff with the operations manager and Registered Manager. They suggested that having reviewed the incidents it could be due to the way in which staff physically approached the person, their positioning or that the holds had been unsuccessful due to the challenging level of the behaviours. They told us they would work on this in further training with staff. They were also looking for other ways to reduce physical intervention.

In response to concerns about injuries to members of staff the registered manager told us regular debrief meetings were being held with the core staff team of the person who used the service involved in all but one of the recorded incidents, to try to re-establish the persons communication system. We saw from the meeting minutes this was also to analyse the behavioural incidents and the concerns of staff and suggest ways to reduce risks through improved management and support to the individual who used the service. The meeting was about the specifics of interactions with the person as the managers felt not sticking to the specific behaviour support plan was causing incidents. This showed individual incidents had been reviewed with a view to reducing risks to staff and people who use the service

Staff were praised for their hard work with the person. The manager told us staff were given the option of continuing to work with the person or not and the staff we spoke with confirmed this was the case. Split shifts were also discussed as a way of giving staff a break from the intense behaviour, but the staff team rejected this idea.

The former deputy manager, now behavioural specialist, was working alongside staff to help develop more structure and predictability for the person. They had also made a Makaton video about the individual's communication system to use when training staff to support the person. An outpatient appointment has been made regarding medication. We saw in the behavioural support plan for the person that first on the list of 'reactive strategies' was to "Try to alleviate the possible causes from my distress by following my PRN protocol." The person has been found to have a health problem which was causing pain and was due to be treated that week.

The operations manager told us they had held a Mental Capacity Act and best interest meeting regarding the person, which agreed it would be in the persons best interests to allow staff to close the bedroom door on the person and leave them alone in the bedroom for a

Good

Is the service safe?

specified, planned , recorded and reviewed length of time if behaviour became a risk to others in order to protect staff. This would also de-escalate the behaviour, by removing triggers and protect the person from accidental harm during behavioural incidents. This meeting was held internally, but also agree by the person's social worker. The operations manager also advised staff to purchase a protective 'box' as used in sport, which would be paid for by the service. This showed individual incidents had been reviewed with a view to reducing risks to staff and people who use the service.

Prior to this inspection we received information of concern about the management of behaviour that challenges causing injury to staff and people who use the service due to a lack of suitably experienced, trained staff and concerns that staff were not supported appropriately

People who used the service we spoke with believed there were normally enough staff. One person told us they were sometimes short staffed. They said staff knew what they were doing and one person who used the service said, "They are well trained." One relative we spoke with said about staff that there were "different faces each visit," and this could be unsettling for their relative.

Three members of staff we spoke with said staffing levels had improved due to a push on recruitment however a lot of new staff and agency staff could be problematic in terms of achieving the right level of skills and experience to manage people's behaviour. Two staff members said that there were enough staff but not all had enough experience or relevant training and this could put staff in danger. One said, "There are enough staff, but not enough experienced staff. Not a lot of people stay for the experience. They have the training, but not the experience. With autism people need consistency." One member of staff told us, "I think there are enough staff." Two members of staff we spoke with said there were not always enough experienced or trained staff which affected staff morale.

We spoke to the registered manager about this and they told us an extra staff member had been put on duty from 10am-3pm daily to help out. The registered manager showed us the work they had done to retain new staff and that since the last inspection in September 2015 20 out of 22 new staff member had been retained by the service. Agency staff had been used and they were planned on to the rota and not used to cover for sickness. The registered manager told us they would no longer be using agency staff from the end of this week as all vacant posts had been filled.

In the event of staff absence a system of reserve staff was in place, so that experienced members of staff could be called in to support service users and the two deputy managers could provide direct support to people who used the service for 30 hours each if required. This showed the service had contingency plans in place to enable it to respond to unexpected changes in staff availability and meant the service to people using it could always be maintained. The deputy manager told us staff sickness had improved and the registered manager had done all they could to improve morale.

On the day of our visit there were 22 staff who had signed on duty for 16 people who used the service. There was no domestic or cook as support workers completed all domestic and cleaning duties. We saw from the rotas and sign in sheets that there were five waking night staff and one sleep in staff member across the service. The manager told us that each person who used the service was allocated staffing according to their assessed needs and we saw that this was reflected in care records and tallied with the number of staff on the duty rota. We cross referenced staff rotas and training records with recorded behavioural incidents and found that the minimum levels of appropriately trained staff had been achieved. At this inspection we saw there were enough suitably trained staff on duty to meet people's individual needs and keep them safe.

At the last inspection staff told us and we saw from the rotas that staff shifts were sometimes long and we discussed with the manager whether this was safe practice for staff to work whilst they were likely to be tired. For example, we saw some staff worked 14 hour shifts and their total working week was in excess of 70 hours. At this inspection staff told us the registered manager had reviewed staff working hours and now kept the maximum working week to 45 hours where possible. Staff still worked a variety of shifts, including14 hour shifts which were still required to provide continuity of care for those people who used the service for whom change provoked anxiety and distress.

The provider had systems in place to make sure staff were suitable to work with people using the service. Staff

Good

Is the service safe?

recruitment files we looked at included application forms, references, proof of identity and Disclosure and Barring Service checks. One staff member said, "Induction is very thorough with training that must be completed before you can start to work." We looked at six staff files. They contained training certificates which showed that staff had completed mandatory training in areas such as; safeguarding, mental capacity, health and safety and fire safety. Files also contained evidence that staff had undertaken training specific to the service, for example, physical techniques for those people who could pose a high risk. Two staff who had been recruited in the last few months told us the recruitment process was "very thorough". Staff told us new starters do all their training before they start now and they do a lot more induction and shadowing. This demonstrated that new employees were supported in their role.

We spoke with five staff about their understanding of keeping people safe and how they would act if they had any concerns that someone might be being abused. Staff we spoke with were clear about their responsibilities to ensure people were protected from abuse and they understood the procedures to follow to report any concerns or allegations. One staff member told us, "I know I could raise any concerns with the registered manager, but if I needed to, I could go to the local authority." Another staff member said, "There are our own internal procedures such as telling the most senior person on duty but I know that I could also report abuse directly to the local authority." Staff were confident that the provider would take any action needed to make sure people who used the service were safe. Staff knew the whistleblowing procedure and said they would be confident to report any bad practice in order to ensure people's rights were protected. This showed staff were aware of how to raise concerns about harm or abuse and recognised their personal responsibilities for safeguarding people using the service.

The registered manager told us all staff completed safeguarding adults training as part of their induction training. Staff told us they had completed the training and the training records we looked at confirmed this. The provider had a policy for whistleblowing. We saw that safeguarding incidents had been dealt with appropriately when they arose and safeguarding authorities and CQC had always been notified in line with policy and guidance. This showed the managers were aware of their responsibilities in relation to safeguarding the people they cared for.

The members of staff we spoke with understood people's individual risks and how to ensure risks were minimised whilst promoting people's independence. Staff told us individual risk management plans were in people's care plans and detailed specific situations, possible risks and how these could be minimised. Staff showed us a 'house risk assessment' for common areas and common risks. When asked to give an example where risk has been managed well one member of staff told us a person who used the service could present a risk to themselves when using the kitchen when anxious. To manage this risk the layout of the kitchen has been redesigned and a 'one cup' kettle with a surface that does not get hot was used. This showed the service had a risk management system in place which ensured risks were managed without impinging on people's rights and freedoms.

Requires improvement

Is the service well-led?

Our findings

The registered manager of Whitwood Grange had been the registered manager of another location run by the same provider and had been in post as manager of Whitwood Grange for around 3 months on a full time basis after the previous registered manager of the service left in August 2015. Two deputy managers worked 40 hours a week and the operations manager visited the home on a weekly basis. Five senior support workers and three supervisors were also in post with some managerial responsibilities, including PRD's, appraisal, and staff support.

The registered manager said they felt supported by the operations manager and spoke with them on a daily basis. The registered manager showed us the weekly operations report they sent to the operations manager. This includes complaints, whistle blowers, compliments, quality monitoring and incidents. The operations manager then sent a monthly operations report to the regional director. Serious incident reports were completed to the operations manager and regional director to escalate to the board if required. Only two of the incidents where staff received a blow to the head were reported as serious incidents and this was because of involvement of the police or public in the behavioural incidents concerned. The registered manager told us the regional manager also received the minutes of clinical meetings that had been held regarding managing people's behaviour and were aware of incidents on the ground and what action is being taken to reduce risks.

The registered manager showed us the monthly health and safety report which was sent to the operations manager for November 2015 on the computer. We saw from accidents and incidents in November 2015 that there were fifteen incidents recorded. Thirteen of these were assaults by people who used the service on members of staff. Action taken was noted on the computer system and in all fifteen cases, "first aid applied" was recorded. In twelve cases, "behaviour support team involved" was recorded. Two involved bruising and swelling, 5 scratches to face neck or chest and two bites to finger or arm. Four of the assaults to staff incidents involved blows to the head and there was also an incident on 30 October 2015 where two staff members received a blow to the head. One incident reports stated, "(person) kicked (staff member) in head causing them to hit the wall." And another said, "(person) wrapped legs round (staff members) neck. (Staff members) head hit floor." Major risks identified was entitled 'none'. This section says, "Please indicate who has been seriously injured, what happened and any RIDDOR, remedial action or legal." Whilst the incidents involving a blow to the head did not legally require reporting to RIDDOR, these incidents were not recorded as a 'major risk' to staff safety.

Whilst individual incidents were managed well and action had been taken to support the individual whose behaviour had escalated we did not see any evidence that the senior management of the organisation had analysed accidents and incidents to look for themes in order to mitigate risks to staff. For example we saw there were six incidents within one month where staff had received a blow to the head, however there was no record that this had been flagged as a concern by senior managers or investigated. This was a breach of Regulation 17 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not done all that was reasonably practicable to assess, monitor and mitigate risks to staff. We have asked the provider to complete a report detailing their investigation of incidents of blows to the head to staff within the service and how they have implemented the learning from this investigation to reduce risks to people.

All the staff we spoke with had confidence in the registered manager. Staff told us they could make suggestions to improve the service and these would be acted upon, for example one member of staff suggesting changes to keyworker care plan meetings that were held and these were implemented. This demonstrated staff were supported to question practice and make suggestions for service improvement.

The registered manager regularly worked with staff 'on the floor' providing support to people who lived there, which meant they had an in-depth knowledge of needs and preferences of the people they supported. We saw on the staff notice board 32 staff members had signed a note in November which said, "We would like to float (managers name's) boat for all her hard work, support and commitment when things get difficult. Top manager. Top team player." The operations manager had recognised the work of the registered manager at their performance appraisal in November 2015 with retaining new staff, reducing sickness absence and implementing new processes and procedures including regular staff supervision.

Requires improvement

Is the service well-led?

When asked about the culture and objectives of the service staff told us it was about empowering people who used the service and one gave an example of a person who was planning to move on to their own tenancy with the support of the service. Another staff member said it was about, "doing the right thing by residents." Staff told us the best thing about the service was it was a good person centred service and the residents were happy. This demonstrated there was an open and transparent culture at the service for staff**.**

The manager held staff meetings on a regular basis. Topics discussed at staff meeting included the management structure, staff hours, staffing levels and supporting new starters, deadlines and audits, infection control, COSHH, 'float you boat' feedback to boost morale, communication and debriefs around previous behavioural incidents. Staff meetings are an important part of the provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and treatment for people living at the home.

The service had conducted a staff questionnaire to gain feedback from staff. The questionnaire covered areas including staff support, training, shift requirements and how to support new starters. Most staff who had responded to the survey saw their manager at least once a day, except night staff. Most staff were positive about supporting service users and team work at the service.

One member of staff said in their feedback, "Due to recent incidents/ behaviours on a night, I feel two male PBS (positive behavioural support) trained to work in (unit) at all times." Two staff members asked on their staff surveys not to work in one house, where the most behavioural incidents had occurred, as they were not confident to do so. The registered manager had noted on the surveys they would, "discuss how they can increase (persons) confidence there."

Of the 21 staff surveyed, three requested shorter shifts. Two long standing members of staff had stated on the survey that they had not had supervision in the last three months and the manager had recorded the subsequent supervision date on the survey form. This showed the registered manager was acting on feedback from staff to improve the quality of the service.

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 17 HSCA (RA) Regulations 2014 Good governance The provider did not assess, monitor and mitigate the risks relating to the health, safety and welfare of staff who may be at risk which arise from the carrying on of the regulated activity. Regulation 17 (2) (b)