The Edmund Trust

Pauline Burnet 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?	Good
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

Pauline Burnet House is registered to provide accommodation for up to eight people who require nursing or personal care. At the time of our inspection there were eight people living at the service. Accommodation is provided on both floors of the two storey building and all bedrooms are single rooms.

At our previous inspection on 11 April 2014 the provider was meeting the regulations that we assessed. This unannounced inspection took place on 8 September 2015.

The service had a registered manager. The registered manager also managed four other locations registered by the provider. 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.

Summary of findings

The provider's recruitment process was robust. This helped ensure that only those staff who were deemed suitable to work with people using the service were offered employment. There was a sufficient number of suitably qualified and experienced staff working at the service. An induction process was in place to support and develop new staff.

Staff's competency to safely administer medicines was assessed regularly to ensure they adhered to safe practice. This was after staff had successfully completed medicines administration training. However, not all medicines were recorded accurately or stored as safely as they should have been. This was in contravention of the provider's policy and put people at risk of unsafe medicines administration.

Staff had been trained in protecting people from harm. They were knowledgeable about reporting suspected or actual harm and had a good understanding of what protecting people from harm meant.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The service's manager and staff were knowledgeable about assessing people's ability to make specific decisions about their care needs. Staff were aware of the circumstances and conditions when an application to lawfully deprive any person of their liberty was required.

People's care was provided with compassion and in a dignified and private manner. People were encouraged to be as independent as practicable with their day to day living skills, choices and preferences.

People's care records were reviewed regularly and kept up-to-date by staff. This was to help ensure that people were provided with care and support based upon the person's latest and most up-to-date care information.

People were involved in their care planning and were supported by relatives, staff and social workers. An advocacy service was available if people required, or were identified as needing, this support.

People were supported to access a range of health care professionals including speech and language therapists, GP and opticians. Advice and guidance provided to staff by health care professionals was followed and adhered. Prompt action was taken in response to the people's changing health care needs. Risk assessments were in place to help manage each person's assessed health risks.

People were encouraged and supported to eat a healthy balanced diet which was appropriate for their needs. People were supported to have sufficient quantities of the food and drinks that they preferred.

People, their relatives and staff were provided with information and guidance about how to raise compliments or concerns. Staff knew how to respond to any reported concerns or suggestions. Not all complaints were recorded. This limited the registered manager's and provider's ability to respond effectively to concerns.

The provider, registered manager and the service's manager had audits and quality assurance processes and procedures in place. However, not all audits were effective in identifying the issues we found.

Staff were supported to develop their skills, increase their knowledge and obtain additional care related and management qualifications.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take in 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.

There was a sufficient number of trained and suitably qualified staff to safely meet people's needs. Medicines' administration records were not always accurate and some medicines were not stored as safely as they should have been. This meant that people were at risk of being unsafely supported with their medicines.

A robust recruitment process was in place to help ensure that staff were only offered employment after their suitability to work at the service had been satisfactorily established.

Risk assessments and management plans were in place to help ensure people were safely supported.

Is the service effective?

Good 

The service was effective.

People were supported to make decisions and their choices were respected. Where required, people who could not always make their decisions were supported to make these in the person's best interests.

Staff supported people to access the most appropriate health care professional. Heath care professional advice was adhered to.

People were offered a choice of food and drink options. People were supported to ensure their diet helped them maintain a healthy lifestyle.

Is the service caring?

Good 

The service was caring.

People's care was provided by staff who were enthusiastic in providing this with compassion. Staff knew people's needs well and how to respond to these in a caring way.

Staff knew what really made a difference to people's lives.

Regular opportunities were provided for people to improve their daily living skills and levels of independence.

Is the service responsive?

Requires improvement 

The service was not always responsive.

Complaints were considered as a way of recognising where there were opportunities for improvements. However, these were not always recorded.

People's aspirations were supported and met by staff who knew what people did well and where additional support was required.

Summary of findings

Information from the person, their relatives, care staff and social workers was used to inform the person's assessed care needs.

Is the service well-led?

Requires improvement

The service was not always well-led.

The provider and registered manager had audits and quality assurance processes in place. However, these were not always effective.

Staff's skills were kept current and up-to-date.

People, staff and relatives were provided with opportunities to discuss and resolve any concerns with the provider.

Pauline Burnet 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 unannounced inspection took place on 8 September 2015 and was completed by one inspector.

Before the inspection we looked at information we hold about the service. This included the number and type of notifications. A notification is information about important events which the provider is required to tell us about by law.

We also spoke with the service's commissioners that pay for people's care, and received information from the local authority's Learning Disability Partnership.

Not everyone was able to speak with us. This was due to people's complex health needs. During the inspection we spoke with four people living at the service, the service's manager, the care services' manager and four care staff.

We also observed people's care to assist us in understanding the quality of care people received.

We looked at three people's care records, records of meetings attended by people who lived at the service and staff. We looked at medicine administration records and records in relation to the management of the service such as checks on matters affecting people's health and safety. We also looked at staff recruitment, supervision and appraisal process records, training records, and complaint and quality assurance records.

Requires improvement

Is the service safe?

Our findings

People told us that they were safe living at the service. We saw that staff understood how people communicated verbally and through the use of body language if they felt unsafe or concerned about anything. One person said, "I feel safe as there are always staff [when you need them]." We saw that some people had monitoring equipment in place to alert staff to their movements, especially at night. This helped staff support people who were not able to ask for assistance.

Staff were trained in medicines' administration and had their competency to administer people's medicines assessed regularly. We found that medicines administration records (MAR) included information on the level of support each person required with their medicines administration. This included those medicines which had to be administered with food or in a fluid form. Not all medicines were stored as securely as they should have been. This was also in contravention of the provider's medicines policies. Staff were able to tell us about the requirements to support people with their medication when they were outside of the home. For example, some people's health conditions sometimes required emergency medicines to be administered. However, not all staff knew the circumstances under which some medications had to be administered. This information was also missing from the medication administration records (MAR). This meant that we could not be confident that people's medicines were being managed safely.

This was a breach of Regulation 12 (1) (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received regular training on how to protect people from harm and they were knowledgeable about the signs of harm. They knew who and how reporting should be undertaken to. This was for any identified or suspected concerns. Staff were also confident to report any poor standards of care by whistle blowing if required. Although incidents such as safeguarding and falls were recorded, there was no service specific guidance in place to support staff on what to report to the service or registered manager. This meant that the registered manager may not always be kept informed of the events they may have needed to be aware of.

Staff told us about their recruitment checks and induction prior to being offered employment with the service. These checks included those for recent photographic identity, staff's previous employment history, evidence of any unacceptable criminal records (Disclosure and Barring Service) and written and corroborated references.

Risks to people, including those for safe moving and handling, travel in the community and health conditions were recorded and regularly reviewed. Risks people exhibited, took or were exposed to were considered on a day to day basis. This was due to any potential change to the risk. For example, the weather, the person's well-being or the number of staff available. This was to help ensure that the most appropriate risk mitigation measures were in place. One person showed us their mobile phone, confirmed that staff could contact them by this and that it provided reassurance if they need any support. We saw that staff gave people as long as the person wanted to complete their chosen activity. One care staff said, "It is so nice to be able to give the person the time they need and not just the time we have."

People told us that they were able to take risks such as going out independently to local shops and cafes. One person said, "I need [two] staff to help me keep safe." Records viewed confirmed this. Care staff told us and we saw that some people were supported with two staff. This was for those people whose assessed needs required this support for their safety. Another person said, "I [need a monitor] in my room so that staff can hear [if I am alright]."

The service manager told us that as part of people's assessment of needs, staffing levels needed to meet these were considered in meeting people's support requirements. They said, "We are actively recruiting seven more staff and they will be the right staff with the right qualifications and not just someone to fill a vacancy." During our inspection we saw that there were sufficient numbers of staff to meet people's care needs. One member of staff said, "I like working here as we are not expected to complete tasks in a certain time. We take as long as the person needs."

The registered manager and service manager had arrangements in place to ensure that there were sufficient staff when there were unplanned absences. These included

Requires improvement

Is the service safe?

the use of agency care staff as well as offering overtime and covering shifts themselves. They told us that a consistent staff team was key to ensuring people's safety. This was due to people having complex care needs and anxieties.

Good

Is the service effective?

Our findings

Our observations showed us that staff had a very good understanding and knowledge of how people's care needs were met. One relative said, "My [family member] can do much more than when they lived at home." A person said, "Staff know me well." We saw that staff's knowledge of people's needs enabled them to respond in the most appropriate manner. This was demonstrated by examples including when staff recognised when a person was happy, in pain or requested something and how best to respond to any given situation. For example, if a person exhibited a health condition requiring urgent attention.

Staff had received training on the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff were very knowledgeable about the MCA and the DoLS and were able to describe the specific decisions people could make and also where people required support with their decision making. Staff were aware that they always assumed a person had capacity but any changes in people's health conditions could mean that in future DoLS applications may be needed. One care staff said, "Some people need medicines with their food and the GP has prescribed them in their (people's) best interests." We found that the decisions people could or could not make and those in the person's best interests had been agreed by the relevant health care professional. We saw that risk assessments showed how people could take risks and make unsafe decisions [within the MCA].

Staff told us that they had the training they required to meet people's needs effectively. This was planned and delivered to ensure that they had the skills and sufficient knowledge. The service manager confirmed that new staff were completing the 'Care Certificate'. This is a nationally recognised qualification in the standards of care to be provided. Subjects deemed mandatory by the service provider included infection prevention and control, medicines administration safeguarding people from harm and moving and handling. Other specialist training included; people living with dementia, epilepsy and behaviours which could challenge others. This training, staff told us, was based upon each person's individualised care needs. This helped promote respect and a reduction of conflict and behaviors' which could challenge others through developing positive interactions and relationships.

The service manager and staff confirmed that they were well supported. One staff member said, "I have the service manager's mobile phone number and I can call this at any time. Another care staff said, "I have just had a formal supervision. I can request additional training and support if I ever feel the need." Another member of staff told us, "We can and do discuss anonymised situations at staff meetings on how best to improve the care people receive." Staff gave us examples of where people's levels of independence had improved and that this had been as a result of the training provided. A third member of staff said, "As people get older having knowledge about dementia will help me understand their needs better."

We saw that prior to people going out into the community they had eaten breakfast and had plans to eat and drink out during the day. People showed us the fruit they were eating as well as having access to other snacks and drinks throughout the day. We looked at the records and details of how people's food and fluid intake levels were determined and monitored. This included supporting people to make healthy living choices whilst respecting people's preferences. Where, people were at an increased risk of dehydration or malnutrition measures were in place for staff to monitor this and act accordingly if safe levels were not maintained.

We saw that staff responded to changes and improvements in people's health conditions. This was by supporting people to access their health care professionals. Appropriate referrals were made to health care professionals and that these were followed up with any outpatient appointments or visits to the person living at the service. This included a dietician, GP, or chiropodist. A 'Hospital Passport document was provided for each person. This is a document which is intended to help ensure that people were safely supported if they had to be admitted to hospital.

Good

Is the service caring?

Our findings

People were supported by their key worker. Meetings were used to help people with their decision making. One person said, "I like all the staff I don't have any (favourites)." Another person we saw being assisted with their moving and handling was spoken with in a reassuring and polite manner. At all times staff sought assurance that the person was safe, that they were not going to catch themselves on the equipment and that once the move was completed they asked if the person wanted anything such as "a drink." We saw much laughter and people being engaged in general conversations with care staff and visiting relatives. Another person said, "It is nice here."

We saw and people confirmed that staff always spoke with them in a respectful way. This was also in a way which respected what people communicated with their body language and facial expressions. One care staff said, "I love working here, seeing the difference I make to people's lives. No two days are ever the same and that's what I like." We saw that one person was celebrating a special occasion and that staff had baked a cake and prepared a tea to celebrate the event. The person expressed they were happy with this by 'smiling'.

We saw that staff regularly sought assurance that people were well, if they needed anything and if they were comfortable. We observed that staff responded appropriately where this was required. For example, one person required two staff to help them move. This ensured this was done in a way which did not cause undue distress or anxieties. One person said, "I am going out [to the day centre] today and [name of staff] is helping me." We saw that other people were supported at the service in a caring way with their chosen interests past-times and hobbies.

Staff described how they respected people's privacy and dignity. This was by covering people with a towel before and after any personal care, giving people privacy in the shower and distracting people with general meaningful conversation whilst personal care was provided. One person confirmed to us that this was the case. Other examples included closing the person's bathroom or bedroom doors. Staff said, "I always ask permission before entering the person's room and ask "Is it alright (to provide care)." Throughout the day we saw that staff attended to people's needs. This was undertaken in a sensitive, prompt and understanding manner. Staff understood each person's wishes and preferences.

We found that for people who required support with an advocate that this support was available. Advocacy is for people who can't always speak up for themselves and provides a voice for them. The service manager told us that most people were supported by relatives but that access to advocacy was available if this was required.

People were involved in the reviews of their care. This was by day to day conversations and meetings with staff. People's input also included the person's preferred means of communication such as pointing to objects of reference, staff's knowledge, and best interest decisions. In addition, family members' views and advice from social workers were used to inform the person's care plan. This was to help ensure staff supported people in the most sensitive way whilst respecting people's independence skills. This was either by the person's key worker [someone who has specific responsibilities regarding the person's care] at a face to face meeting or at more formal reviews of care plans. The service manager showed us the new versions of people's care plans which we found were personalised for each person. They told us that the new plans were based on what the person wanted rather than what staff thought they wanted.

We saw that people's care records were up-to-date, in an appropriate format [easy read] where required and contained detailed guidance on the care people needed. These records included a record of people's life histories, what their aspirations and goals were and how they were to be met. They also included the triggers for people's behaviours which could challenge others and how to manage these safely.

People told us, staff confirmed and we saw that relatives and friends could call in to see people at any time people were in and with the person's agreement. One person told us that they went to see their relative on a weekend. We saw in people's care records how people were supported to keep in touch with family members by e-mail, letter and telephone. Records and staff confirmed this happened.

Requires improvement

Is the service responsive?

Our findings

We were told by people of the meaningful interests they took part in. This included going out, to their favourite day centre, to a zoo and to local country parks. One person indicated to us that they liked to swim. Another person said, "I like everywhere I go (out). One care staff said, "[Name of person] had requested to go bowling so this is what we did and it was an amazing day (for them)." All staff saw the abilities people had and what goals and achievements people aspired to.

We saw and found that complaints had not always been recorded. This limited the registered manager's and provider's ability to respond in a way which was to the complainant's satisfaction. This also increased the risk of the service not responding in the most appropriate way to any concerns raised.

We found that the service over a recent five month period had not had a driver available for the service's vehicle to take people out as much as they could have been. Some interim measures had been implemented recently but the service manager told us it was "always a struggle to get a driver." The service's manager told us that some opportunities had been missed such as whilst staff were out shopping to include people in this. This meant that for some people their preferred hobbies and interest were not supported during this period as well as they could have been.

Prior to people living at the service an assessment of their needs was undertaken. In addition, the recorded information built up over several years at the service was used to inform people's care planning and delivery. This information was then used to form the basis of each person's care needs. This was planned to help ensure that the service and its staff were able to respond to, and safely meet, people's needs. People were involved in having person centred care plans as much as possible. One care staff said, "I have not worked here very long but I have already seen, and they (the service's commissioners) have commented on the things [name of person] can do which they have not done or tried before." One person said, "I like all the things I do."

People were supported to take part in hobbies and interest that were important to them. For example, going to the pub, going out for a coffee, completing puzzles and going to the bank. We saw in people's care records how people were supported to decide on the subjects they wanted to undertake each day, if they had any new goals or ambitions and how staff were required to help people achieve these. We observed and found that people's requests were responded to by staff with enthusiasm. One care staff said, "Nothing is too much trouble for them (people).

We saw and were told by staff that some people required a call bell or monitoring equipment in their rooms. This was to ensure that any requests for assistance were responded to promptly and in the way the person wanted.

We saw that people's care plans were in an easy read format. These care plans included various methods to involve people with their communication skills. For example by showing staff pictures or objects that the person wanted support with. This was planned to help ensure that people had care which was based upon their individual needs (person centred). One person confirmed to us that staff gave them as much time as they need with their care and support needs.

Requires improvement

Is the service well-led?

Our findings

People's views about their satisfaction of their care were sought regularly and in the most appropriate way. This included staff spending time with people, seeking the person's views, using people's expressions and body language and preferred means of communication. One care staff told us how they spent time with people on a daily basis and discussed subjects on what the person felt, or expressed, had gone well and what areas if any required attention. The service's staff explained to us how they identified what worked best for each person. This was by analysing incident data. For example, the numbers of seizures people experienced and the potential reasons for this. For example, the time of day or the activity the person was engaged in. The service manager looked at what action to help prevent these had been effective.

Quality assurance checks completed by the provider, registered manager, service and care services manager had not always been effective in identifying the issues we found. For example, where people's medicines had stopped, MAR sheets did not accurately reflect the medicines people had been prescribed. Not all medicines were stored as securely as they should have been. Audits completed on two occasions in August 2015 had not identified these issues. In another example we found that the fire safety risk assessment had not been updated to reflect that there were eight rather than seven people living at the service. This put people at risk of unsafe, inappropriate care and care that might not safely meet their needs.

Staff meetings gave staff the opportunity to comment on any areas they felt were in need of actions. Information from these meetings was used to drive improvement in the standard of service provided. We saw from meeting minutes that actions had been taken. For example, providing people with more one to one time or changing the room people lived in. This was to support people with easier access to the bathrooms. One care staff said, "I am never afraid to raise any issues or suggestions. Wherever possible my suggestions are put into practice."

Strong links were maintained with the local community and included various trips out to local cafes, shops and banks. One person indicated to us and staff confirmed that they liked going out to buy jewellery. Another person told us how much they had enjoyed going to their day centre

Staff were regularly reminded of their roles and responsibilities and how to escalate any issues or concerns. This was through formal supervision, staff meeting or at shift hand overs.

The service manager and care services manager also worked some shifts, completed spot checks and worked with staff at night or weekends. This was to mentor staff with key skills whilst also identifying the staff culture. The service's commissioners told us, "Since a recent incident much better awareness by staff is in place to ensure people's care is as good as it could possibly be." Staff spoke confidently about how well they worked together and that it was generally a relaxed but busy place to work. One person said, "I see them (managers) most days and they ask how I am."

Staff all told us that they would have no hesitation, if ever they identified or suspected poor care standards in whistle blowing. This was by reporting their concerns to the provider Staff also told us that they were confident that there would not be any recriminations if they did this.

From records viewed we found the registered manager had notified the Care Quality Commission (CQC) of incidents and events they are required to tell us about. We found from these notifications, where trends were identified that appropriate action and referrals were made. For example where additional staff training was required.

We saw that the service manager, care services manager and all staff worked as a team. The registered manager visited the service approximately every four weeks. The various managers for and from the service attended the provider's managers' monthly meetings where information was shared on good and best practice. For example, taking more effective action on issues raised about the quality of care provided. Information from the Medicines and Health Regulatory Authority was shared with service managers about any changes in people's prescribed medications. This also included information from organisations such as the Social Care Institute for Excellence (SCIE). This was for subjects including changes to care practice for people with a learning disability. At the time of our inspection there were no staff champions in place for subjects including nutrition and epilepsy. The service manager told us that they had identified this and plans were in place to support people such as people living with, or who could develop, dementia.

Requires improvement

Is the service well-led?

The registered manager, through the service and care services manager, monitored all staff training achievements. This helped them determine any action to be taken regarding any uncompleted training. The service's manager was keen to develop staff's knowledge. We saw that guidance from various organisations to support people with their health conditions was in place. This included the Autistic Society, for people living with autism and Scope (This is a charity that exists to support people with a disability to have the same opportunities as everyone else).

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 How the regulation was not being met: People's medicines were not always stored safely. This put people at risk of harm. Regulation 12 (1) (2) (g).