Psycare Limited

Winnett Cottage

Inspection report

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26 May 2016

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of Winnett Cottage on 11 and 16 December 2015. At this inspection we found breaches of regulations 09, 13, 16 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also identified a breach of Regulation 18 of the Care Quality Commission Registration Regulations 2009. The provider submitted an action plan that told us they would meet the minimum requirements by 29 April 2016.
We carried out an unannounced focused inspection of Winnett Cottage on 26 May 2016 and found improvements had been made.

This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Winnett Cottage on our website at www.cqc.org.uk.

Winnett Cottage is registered to provide residential care for up twelve people living with mental health needs. At the time of our inspection ten people were living at Winnett Cottage.

The home did not have a registered manager in post, however at the time of the inspection they had begun the registration process. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

We found that the manager had reviewed and investigated all incidents and accidents to keep people safe from the risk of harm or abuse. Risk assessments had been developed to positively manage risks to people.

Staff were aware of people's individual needs and how to respond to these. People felt listened to, and felt the changes made to their care planning was an improvement.

People received care that was well led by. Regular reviews of the quality of care people received were carried out by the manager and provider. People's care records were now stored securely. People's views about the quality of service they received had been sought and the manager had reported untoward incidents to the local authority, police, and CQC as required.

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.

People were protected from harm because a system of reporting, reviewing and identifying risks to people was robust and consistent.

People at risk of harm, had appropriate assessments and actions taken to mitigate the risk of harm from happening.

Is the service responsive?

Good

The service was responsive.

People received care that was responsive to their individual needs.

Complaints received had been appropriately investigated, recorded and responded to.

Is the service well-led?

Good

The service was well led.

The manager had reviewed the service and developed a comprehensive service improvement plan.

People's records were stored securely and were available when requested.

Notifications that were required to be made to CQC and other professional bodies had been made as required.

Winnett 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 was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012 and to look at the overall quality of the service.

This inspection took place on 26 May 2016 and was unannounced. The inspection team consisted of one inspector.

Before our inspection, we reviewed the information we held about the home, which included a copy of the action plan the provider had sent us, explaining how they would meet the requirements set at the previous inspection. We contacted the Commissioners of the service and one healthcare professional to obtain their views about the care provided in the home.

We reviewed information we held about the service including statutory notifications and enquiries relating to the service. Statutory notifications include information about important events which the provider is required to send us.

During the visit, we spoke with three people who used the service, the manager and a visiting health professional. We looked at the care records for three people living at the home, and records relevant to the management of the service.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Winnett Cottage. One person told us, "It's better now than it was."

Untoward incidents that took place in the home were managed well. The manager had reviewed the reporting process in the home and constantly reviewed and checked that staff had both reported the incident correctly, and that necessary actions had taken place. For example, one person had experienced deterioration in their mobility, which had caused them to become less mobile, increasing their risk of falling and injuring themselves. We saw the manager had identified this trend both through monitoring and reviewing the frequency of incidents, and by effectively reviewing the person's care needs. This triggered them to refer the person to the GP for follow up investigation, and also to support them to acquire the appropriate mobility aids. Staff had reviewed the persons care, and had reduced the frequency of incidents by their actions. This person told us, "They [staff] are brilliant with helping me."

We noted further examples of how the manager had acted throughout the previous six months where people had either used or allegedly brought illicit substances into Winnett Cottage. The manager had proactively requested the police to visit the home and speak to everyone, in addition to increasing their presence locally. When incidents occurred, the manager reported these to the police, Social Services and CQC, and reviewed people's care plans accordingly. This meant where incidents identified concerns around the misuse of illicit substances, this had triggered the manager to consider how they may interact with prescribed medicines and to discuss with people's doctor, psychiatrist or social worker. They had furthermore been successful in supporting two people to access local support services for substance misuse.

Where people were at risk of exploitation, through emotional or financial reasons, the manager and staff team had documented what these may be, and for staff to be aware of a person's behaviour. Where previously there was little information to direct staff, we saw the manager had taken the time to support staff with training to develop accurate, informative plans. Care records demonstrated that staff were able to identify and respond to people in a consistent manner when they required support.

This meant the manager had made improvements to help ensure people were protected from harm or unsafe treatment, because a system of reporting, reviewing and identifying risks to people was robust and consistent. They had also ensured that identified risks were responded to effectively.

Good

Is the service responsive?

Our findings

At our last inspection on 11 and 16 December 2016 we found that care plans related to people's mental health needs contained little information for staff to refer to.

We found that people's care in relation to their mental health was now planned in partnership with the person, and better reflected their individual needs and wishes. For example people identified by the manager as being at risk of exploitation, either emotionally or financially had care plans that provided guidance for staff about how to identify, respond to and protect the individual concerned.

The manager identified that staff had not been empowered by the previous registered manager to develop care plans. Therefore they had sought support from a local training provider to improve the staff's confidence and ability in writing care plans. Previously we found that one person who had displayed aggressive and violent behaviour towards others did not have an assessment or plan in place of how to manage this. At this inspection we saw that with the manager's support, staff had developed a plan of care, with the person's involvement, that clearly identified how to support the person with their needs. For example, in managing a person's behaviour positively, staff identified that one person was likely to sell their possessions when agitated. These issues had been discussed with the person and agreed actions were in place on how to support this person, for example with either one to one walks or cookery to distract them. Records of care demonstrated that staff had all applied a consistent approach to supporting this person when needed. One visiting health professional told us, "I have definitely seen an improvement, the staff really help me to understand [persons] needs, when we review they know [person] better than I do, and we can all manage the issues."

This meant that people's care was now planned and delivered in a manner that was responsive to people's individual needs

At our last inspection people told us they were aware of how to make a complaint, however complaints raised had not always been thoroughly reported or investigated. We looked at the complaints log and found only two had been made since our last inspection. We reviewed these to see how the manager had handled them, and saw a thorough investigation of the concerns were undertaken, with the outcome of the investigations reported back to the person in writing. People were encouraged to escalate their complaint if they were unhappy, and the manager had ensured copies of the complaints policy were prominently displayed around the home.

Complaints that were received were discussed in team meetings to allow all staff to reflect on what had occurred and discuss ways to help improve the quality of service received. This meant that complaints were recorded, investigated and responded to appropriately.

Good

Is the service well-led?

Our findings

There was not a registered manager in post as required to manage the service, however the newly employed manager had begun the process of registering with the Care Quality Commission as required. The previous registered manager had left the organisation following our inspection on 11 and 16 December 2015. The current manager had only been in post a short while at this inspection.

The manager had systems in place to audit and monitor the quality of care people received. They showed us copies of reviews of care they had completed which included areas such as incidents, accidents, care planning, medication, health and safety and complaints. Since being in post at Winnett Cottage they had developed a service improvement plan that clearly identified what the issues were, and how they would make the required improvements. The local authority had recently visited the service and as a result of this visit, left the manager some areas to improve upon. They had further developed a plan to address these issues and were proactively addressing the minor concerns raised.

The provider had a range of systems in place to monitor the quality of care people received whilst living at Winnett Cottage. We saw that senior management carried out visits and reviews with the manager, and in addition their own line manager also carried out reviews of the quality of care people received. On a weekly basis the manager completed a report which was sent to the provider for review. This included areas such as complaints, admissions, discharges, incidents, safeguarding concerns and staffing. These were reviewed and any issues arising were discussed and improvements made where needed. The provider had carried out further spot checks within the home which helped them to ensure the service continued to be well led. These reviewed areas such as people's care plans to ensure they were accurate and up to date, the environment, activities and the service improvement plan. An action plan following the previous CQC and local authority reviews of Winnett Cottage had been completed, and the actions had been reviewed by the provider regularly to ensure they were completed. This demonstrated to us that the provider routinely monitored the service to ensure people received high quality care, and took the necessary actions when improvements were needed.

At our previous inspection on 11 and 16 December 2015 we found that statutory notifications that were required to be sent to the commission without delay had not been made. When we reviewed the incidents log for Winnett Cottage at this inspection we found improvements had been made and incidents that were required to be sent to us had been completed in a timely manner. Where the nature of the incident required the manager to inform other professional bodies such as the police or social services, we saw these had also been made. Where incidents had occurred within the home, staff and the manager discussed and reviewed these to gain a better understanding of what had happened, and review the incident and their practise to determine what learning they could take from the event to minimise the likelihood of a recurrence.

At our previous inspection we found that people's confidential records were not stored securely. The previous registered manager had told us that people's records had been removed without authorisation from the office, and when we asked to see copies of records, some were unavailable. At this inspection, the manager was able to provide us with copies of all the information we requested, and also ensured people's

records were stored securely within a locked office.