Parkcare Homes (No.2) Limited

Blyton Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 25 May 2016 and was unannounced.

Blyton Court specialises in the care of people who have a learning disability. It provides accommodation for up to 18 people who require personal and nursing care. On the day of our inspection there were 13 people living at the home. The home is divided into two units the Old Hall which provides accommodation for up to five people and the main unit which provides care for up to 13 people. The units are interconnected but staffed separately.

At the time of our inspection there was not a registered manager in post. 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.

On the day of our inspection we found that staff interacted well with people and people were cared for safely. The provider had systems and processes in place to safeguard people and staff knew how to keep people safe. Risk assessments were in place and accidents and incidents were monitored and recorded. Medicines were administered and stored safely.

The provider acted in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).If the location is a care home Care Quality Commission is required by law to monitor the operation of the DoLS, and to report on what we find.

We found that people's health care needs were assessed and care planned and delivered to meet those needs. People had access to other healthcare professionals such as a dietician and GP. Staff were kind and sensitive to people when they were providing support. Staff knew how to provide care to people. People had limited access to leisure activities and excursions to local facilities.

People had their privacy and dignity considered. Staff were aware of people's need for privacy and dignity.

People were supported to eat enough to keep them healthy. People had access to drinks during the day. People were not offered choices at mealtimes. Where people had special dietary requirements we saw that these were provided for.

There were sufficient staff available to care for people appropriately. Staff were provided with training on a variety of subjects to ensure that they had the skills to meet people's needs.

Staff felt able to raise concerns and issues with management. We found relatives were clear about the process for raising concerns and were confident that they would be listened to. The provider recorded and monitored complaints.

Audits were carried out on a regular basis and action put in place to address any concerns and issues.

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.

Staff had received training and were aware of how to keep people safe from harm.

Staff were aware of risks to people and knew how to manage those risks.

Medicines were stored and handled safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had received training to support them in their role.

People were supported to eat a balanced diet. People were not always offered choices about their meals.

People were supported to access other health professionals and services.

The provider was meeting the requirements of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

There was a warm and pleasant atmosphere in the home and staff were kind and caring to people.

People's privacy and dignity was protected and staff were aware of people's individual need for privacy.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not supported to pursue leisure activities. People accessed the local community.

Care was not always personalised. People had their needs regularly assessed and reviewed.

People were supported to raise issues and concerns. Relatives told us they knew how to complain and would feel able to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

A registered manager was not in post.

Processes were in place to communicate with people and their relatives.

Processes were in place for checking the quality of the service.

Blyton Court

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 25 May 2016 and was unannounced. The inspection team consisted of an inspector and an Expert by Experience (Ex by Ex). 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, the provider completed a Provider Information Return (PIR). 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 also reviewed the information we held about this home including notifications. Notifications are events which providers are required to inform us about.

During our inspection we observed care and spoke with the regional manager, interim manager, four members of care staff, a nurse and the cook. We spoke with two people who were living at the service. We also spoke with two visiting relatives and three relatives by telephone. We looked at four care plans and records of training, complaints, audits and medicines.

Good

Is the service safe?

Our findings

Relatives we spoke with told us that they felt their family member was safe. A person and their relative told us they felt that the service was safe and that the staff and managers were always very good. One relative told us, "No particular issues, yes, it is safe."

Staff that we spoke with were aware of what steps they would take if they suspected that people were at risk of harm. Staff were aware of how to report an incident both internally and externally to the provider. They told us that they had received training to support them in keeping people safe. We saw from the training record that staff had received this training. The provider had safeguarding policies and procedures in place to guide practice. We saw that regular reports were submitted to the local authority regarding any safeguarding issues and concerns.

Individual risk assessments were completed for people who used the service and included guidance on their care needs in order to manage the risk. For example, risk assessments were in place for people who required bed rails to keep them safe at night. The provider consulted with other healthcare professionals when completing risk assessments for people, for example, the GP. Staff were familiar with the risks and were provided with information as to how to manage these risks and ensure people were protected. Accidents and incidents were recorded and investigated to prevent reoccurrence. Plans were in place on an individual basis and for the home as a whole to ensure that people were protected in the event of an unforeseen event such as fire or flood.

A relative told us, "I think there is just enough staff, sometimes I think it is hectic for them." We found that there were sufficient staff on duty to meet people's needs. When there were gaps on the duty rota due to staff sickness these were filled by staff either from one of the provider's other homes or by agency staff in the case of nurses. The interim manager told us that they tried to use the same agency staff in order to provide continuity of care to people. Staff told us there were usually enough people employed by the service. However staff told us that it was better on the days that the activities staff were on duty as they could provide more one to one support to people. The provider had a recruitment process in place which included carrying out checks and obtaining references before staff commenced employment. This was in place to ensure that staff were suitable to work with people.

We saw that medicines were handled and administered safely. Medicines were stored in locked cupboards according to national guidance. Medicine administration records were completed fully and systems were in place to ensure that the member of staff who gave medicines could be identified. This facilitated a check in the event of a medicine error. Where people required specific support with their medicines or required as and when medicines this was recorded clearly to ensure staff could provide appropriate support. For example, most people took their medicine with food. We saw that records detailed how to offer people their medicines so that they were aware that they were taking them and they were in the method preferred by them. Where people required 'rescue medicine' such as when they experienced an epileptic seizure, guidance and risk assessments were in place to ensure that staff knew when it was appropriate to administer this.

Requires Improvement

Is the service effective?

Our findings

People received care from staff that had the knowledge and skills to carry out their roles and responsibilities effectively. One relative said they felt that staff knew what they were doing. Another said, "Staff are well trained, the ones we are dealing with yes."

Staff told us that they felt they received appropriate training to enable them to care for people. The training included statutory training such as fire and health and safety and also topics which were related to the practical care of people such as specialist feeding regimes. Training had not been provided with reference to supporting people's wellbeing for example, training on effective communication. This was important because most of the people in the home were unable to communicate verbally. We saw a training plan was in place and had been updated to reflect what training had taken place and what training was required. Training was provided in a variety of methods for example, face to face and by computer.

The provider had an induction process in place. The induction was in line with national guidance as the provider had recently introduced the Care Certificate. This is a new training scheme supported by the government to give care staff the skills needed to care for people. A system was in place for supervision and appraisal. We saw that these had been carried out on a regular basis. Appraisals provide an opportunity for staff and managers to review performance and ensure that staff have the skills and support to carry out their role.

Where people had specific nutritional needs we saw that plans and assessments were in place to ensure that their needs were met. For example, a record explained that when a person refused their meal a fortified drink should be provided to ensure the person received appropriate nutrition. We observed that the cook was aware of people's needs and told us how they ensured that the meals met people's needs. However meals were provided according to staff's knowledge of people's preferences' rather than offering an actual choice. On the day of our inspection we saw that picture cards were available to inform people what was for lunch however they did not match the meals which were served.

We observed lunchtime and saw that staff provided support and assistance to people in a sensitive manner in order to ensure that people received sufficient and appropriate nutrition. Where people required specialist equipment to support them with their meals this was provided. We saw staff sat with people and chatted with them during lunchtime. People had access to drinks during the day.

We found that people who used the service had access to local healthcare services and received on-going healthcare support from staff. We saw that people had accessed health screening such as the 'well man clinic'. The provider had made appropriate referrals when required for advice and support. Where people had specific health needs such as the need for diabetes, advice and support had been sought and records included how to provide support to people. We saw records of appointments and intervention from other professionals in the care records such as occupational therapy and dentists. People had transfer documents in place which included information about people's health needs so that if they were admitted to hospital or needed to attend a clinic, information was readily available to ensure that they received appropriate

treatment.

Staff understood about consent. Despite people who lived at the home having limited verbal communication staff were encouraged to offer people choices. We observed people refusing care for example, their meals and staff responding appropriately to this. Where people did not have the capacity to consent, the provider acted in accordance with the Mental Capacity Act 2005 (MCA). The MCA protects people who might not be able to make informed decisions on their own about their care or treatment. Where it is judged that a person lacks capacity a person making a decision on their behalf must do this in their best interests. We observed meetings had taken place which involved a range of people including the local authority and people's representatives to consider what was in people's best interests.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The service was applying the Deprivation of Liberty Safeguards (DoLS) appropriately. These safeguards protect the rights of people using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. At the time of our inspection 12 people were subject to a DoLS authorisations.

Good

Is the service caring?

Our findings

All of the relatives we spoke with during our inspection were positive about the care and support people received. A relative said, "They treat [my relative] with dignity and respect." Another told us, "No issues whatsoever, [my relative] has always been happy so we are happy, it's very safe here." Another said, "They treat people with kindness, dignity and respect yes definitely."

We saw that staff interacted in a positive manner with people and that they were sensitive to people's needs. People were treated as individuals and allowed to express how they wanted their care to be provided. For example, when supporting a person with their meal we observed that staff sat beside the person and assisted them, giving them the opportunity to use the spoon themselves. Another person who was unable to communicate verbally made it clear that they were unhappy sitting at the dining table when they had finished their breakfast. We observed that staff understood what the person wanted and supported them to move out of the room.

We saw that caring relationships had developed between people who used the service and staff. We saw that care records included some choices about how they wanted their practical care to be provided and included information regarding people's independence. For example, we observed a member of staff supporting a person to move. We checked in the care record and saw that the staff had followed the guidance in the care record and supported the person appropriately.

People had access to advocacy services. Advocacy services are independent of the service and local authority and can support people to make and communicate their wishes.

Staff we spoke with understood what privacy and dignity meant in relation to supporting people with personal care. Staff spoke discreetly to people and asked them if they required assistance. We saw that staff addressed people by their preferred name and that this was recorded in the person's care record. We observed staff knocked on people's bedroom doors before entering and asked if it was alright to come in. Bedrooms had been personalised with people's belongings, to assist people to feel at home. We saw that there were areas around the home where people could be private if they wished.

Requires Improvement

Is the service responsive?

Our findings

Staff that we spoke with were knowledgeable about people's current likes and dislikes however information relating to people's past experiences was not always available or known by staff. For example, a person was recorded as liking country and western music but staff were unaware of this. Consequently the person was unable to pursue this type of activity. A member of staff told us, "Sometimes it is difficult to be personalised because of the numbers." This meant that staff had to concentrate on completing tasks rather than being flexible around people's needs. The interim manager told us, "Caring and compassion is in abundance, there are person centred elements but it isn't evidenced very well. The nursing team know people well and are robust re delivery but the service is care led rather than support led."

Staff were appointed to provide activities and leisure pursuits however this was on a part time basis. On the day of our inspection the activity staff were not available. We observed limited activities for example a story time group was organised in the morning and a film was put on in the lounge area. However in the afternoon we observed three people sat in the lounge without interaction whilst staff were busy carrying out practical tasks such as doing laundry and responding to the phone. Staff told us that activities within the home included entertainers/singers, watching DVD's, listening to music, soft play area, watching TV. A sensory room was available for people to relax in and enjoy things such as music and visual effects. However we observed that people were left in the room alone and that the music was not turned on. It was not clear from care records if this was their preference.

The home had access to transport and used this to take people into the local community. The interim manager told us that usually trips were visits to places rather than people participating in community activities and events. However they said that people regularly used local facilities such as the local ice cream parlour and hairdressers. Relatives we spoke with told us that they felt welcomed at the home when they visited their family member. One relative said, "I like it that when you arrive they know who you are." People were not always supported to keep in regular contact with their relatives, for example, One relative said, "Wouldn't say they [staff] know [my relative], nephews never get cards, never a father's day card for dad."

We looked at care records for people who used the service. Care records included risk assessments and personal care support plans. Records detailed limited choices people had made as part of their care and who had been involved in discussions about their care. We found records were not always personalised, for example, one person had a sensory impairment and used their sense of smell to assist them to understand the environment, however the care record did not detail the importance of this. Another record stated that a person who was unable to communicate verbally was able to make 'simple' choices but it was not clear from the record how these choices were made. There was not clear guidance to ensure that staff knew how to respond to people. We observed that staff did not always respond appropriately to people's communication and sensory needs, for example, a person who had sight and hearing impairment was taken to sit in story time. Because of the person's sensory limitations it was unclear if they would be able to hear the story and their care records did not indicate that this was something the person would enjoy.

Communication dictionaries were in place to identify how people communicated however these were not

always fully completed. In all the care records we looked at the communication dictionaries were filed at the back of the care plans and were not readily available to staff to ensure that they were aware of how people communicated. Care records had not always been fully completed, for example one person suffered from epilepsy and their health action plan did not include information about this. There was a risk that staff would not be aware of how to respond to people.

Relatives told us that they would know how to complain if they needed to but that they hadn't had cause to do so. People who lived at the home were supported to raise their concerns by the staff in a variety of ways for example at their care review. Although information was available to people regarding complaints the majority of people who lived at the home were unable to access this so staff used other methods such as observation and pictures to ascertain people's views. The interim manager kept a log of complaints and reviewed this on a regular basis in order to identify any trends.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection the home had been without a registered manager for nine months, however a registered manager from another of the provider's homes was working as the interim manager. The provider was in the process of recruiting a registered manager for the home. We found that the interim manager was visible, knew their staff and the people in their care. The people who used the service and their relatives that we spoke with knew who the interim manager was and knew them by name. The interim manager told us that they encouraged people and staff to come and speak with her at any time and that she had an 'open door' policy. They told us that a person particularly liked to be in their office and 'sort' the papers. They told us that this was their home and they felt that they should be able to access the interim manager.

Staff told us that they thought there were good communication arrangements in place which supported them in their role. Staff understood their role within the home and were aware of the lines of accountability. Staff told us that they would feel comfortable raising issues with the senior management and the provider and felt supported in their role. A staff member told us that they all worked as a team and said, "Staff are very supportive and share information" and "There's a good feeling here." Regular staff meetings were held and we saw that issues such as safeguarding and personalised care had been discussed at a meeting in May 2016. In their PIR the provider told us about an award scheme which they had developed to reward innovative practice and quality care. In order to encourage staff involvement.

The provider encouraged regular feedback and used a variety of methods to ensure that people, relatives and visitors were able to comment on the service. Methods included questionnaires and meetings. Questionnaires had been carried out with staff and relatives. Responses had been limited and the regional manager told us that they were repeating the exercise to try and illicit a better response.

The interim manager told us they were responsible for undertaking regular checks of the home. Checks had been carried out on areas such as infection control and health and safety. We saw the records of the checks identified what action was required but not who was responsible or a date for completion of the action. Care records had also been checked to ensure that they included the required information and that staff were able to care for people appropriately. The provider had informed us appropriately about events which they are required by law to tell us about.

The service had a whistleblowing policy and contact numbers to report issues were displayed in communal areas. Staff told us they were confident about raising concerns about any poor practices witnessed. They told us they felt able to raise concerns and issues with the interim manager. The relatives we spoke with told us that they would be happy to raise any concerns they had.