

MacIntyre Care The Grove -6

Inspection report

6 The Grove
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16 November 2018

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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 

Summary of findings

Overall summary

6 The Grove is a care home for up to seven people with learning disabilities and/or autistic spectrum conditions. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection seven people were living at the home.

We checked to see if the care service had been developed and designed in line with the values that underpin 'Registering the Right Support' and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service should be able to live as ordinary a life as any citizen. The provider's values were strongly connected to these principles, which were reflected in the systems and processes used by the service. However, we found aspects of the service did not always uphold these values.

At our last inspection we rated the service as 'good'. At this inspection we rated the service as 'requires improvement'. This was because we found some areas of the service needed work to ensure the service provided consistently good quality support to people.

This unannounced inspection took place between 10 October 2018 and 16 November 2018.

There was 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.

People had detailed risk assessments in place to enable them, in most instances, to be as independent as possible whilst also remaining safe. However, there was insufficient evidence that, where restrictive measures had been in place for a long time, the continuing need for this was fully assessed.

There was information available to people about how to make a complaint, and information for staff on how to understand how people communicated this. However, this information was not used effectively to identify and act on complaints made by people who used the service.

Although people's support plans included basic information about end of life care and funeral plans, this information had not been reviewed or updated for many years.

Support plans were person centred and contained details about people's individual needs and preferences. However, they would have benefitted from a full review to ensure they remained up to date.

Audits and provider quality monitoring visits had taken place but had not identified some issues found at

this inspection.

Some of the people who lived at the service were unable to tell us about their experiences in detail, so we observed the support they received and their interactions with staff to help us understand.

People were clearly comfortable in the presence of staff. Staff had received training to enable them to recognise signs of abuse and they felt confident in how to report these types of concerns.

There were sufficient numbers of skilled staff on duty to support people to have their needs met safely. Effective recruitment processes were in place to ensure only suitable staff were employed.

Medicines were managed safely and administered as prescribed and in a way that met people's individual preferences. The service was clean and people were protected from the risk of infection.

Staff understood and worked in line with the principles of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards. People were mostly supported to have choice and to make decisions and staff mostly supported them to be as independent as possible; the policies and systems in the service supported this practice.

Staff received an induction process and on-going training. They had completed training related to the specific needs of the people using the service to ensure that they were able to provide skilled care based on current good practice. They were also supported with regular supervisions and annual performance reviews (appraisals).

People were supported to have enough to eat and drink and were involved in making choices about meals.

People were supported to access a variety of health professionals when required, including opticians, doctors and specialist nurses to make sure that they received additional healthcare to meet their needs.

Staff knew the people who used the service well. People and relatives, where appropriate, were involved in the planning of their care and support. Where people were unable to be involved, the reason for this was recorded and support plans were written in people's best interests in consultation with people who knew them well.

People's privacy and dignity was maintained and staff treated them with kindness and respect. People were supported to follow their interests and join in activities.

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 consistently safe.

Risk Assessments were detailed and identified risks that were specific to individual people. However, where restrictive practices were in place, there was no evidence that the need for this had been regularly reviewed.

People were protected from abuse because staff understood the signs to look for and the process for reporting concerns.

People were protected from the risk of infection and medicines were managed safely.

There were enough staff deployed to keep people safe and effective staff recruitment reduced the risk of unsuitable staff being employed.

There was evidence that the provider learned from when things went wrong and made improvements to the service.

Is the service effective?

Good ●

The service was effective

The requirements of the Mental Capacity Act were met.

People had enough to eat and drink.

Staff received training to provide them with the skills and knowledge to support people who used the service.

Is the service caring?

Good ●

The service was caring.

People were supported by staff who knew each person well and had a kind, respectful approach.

People were involved in planning their care and support.

People's privacy and dignity were protected.

Is the service responsive?

The service was not consistently responsive.

Support plans were person centred but would have benefitted from full review.

End of life plans had not been recently updated.

Complaints from people using the service had not been managed or recorded sufficiently.

People were encouraged and supported to find meaningful activities to be involved in.

Requires Improvement 

Is the service well-led?

The service was not consistently well led.

Systems to monitor the quality of the service did not identify some issues found at the inspection.

Staff completed surveys on behalf of people who used the service, but no independent support was provided to ensure people's views were accurately represented.

The provider promoted person centred care but some opportunities to uphold these values were missed by the service.

The service worked in partnership with other professionals to meet people's needs.□

Requires Improvement 

The Grove -6

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 comprehensive inspection took between 10 October and 16 November and was unannounced. It was carried out by two inspectors. One inspector carried out the office visit and a second inspector carried out telephone interviews with relatives.

Prior to the inspection we looked at information we held about the service and used this information as part of our inspection planning. The information included notifications. Notifications are information on important events that happen in the service that the provider is required by law to notify us about.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our visit we observed how the staff interacted with people who lived at 6 The Grove. We met two people who lived there, and where they were not able to tell us about their experiences in detail, we observed the interactions between them and staff. We also spoke to staff, including the Registered Manager and care staff on duty. We looked at three people's care records as well as other records and systems relating to the management of the service. These included systems relating to the management of medicines, meeting minutes and audits that had been carried out to check the quality of the service being provided.

After the inspection we contacted two relatives of people who used the service to seek their views about the care provided to their family member.

Is the service safe?

Our findings

The kitchen at 6 the Grove was locked when we first attempted to enter it on the day of the inspection. The registered manager told us this door was only supposed to be locked at night due to a risk to one person who used the service. The person concerned was not in the building at the time, and the registered manager unlocked the door, which remained unlocked for the rest of the day.

The registered manager told us that an incident where the person had burned toast during the night many years ago had led to the decision. This was also influenced by the person being diagnosed with a medical condition which staff thought might increase the risk of further incidents. There was no record of how this decision was reached or how it was meaningfully reviewed to ensure it was the least restrictive action to protect people from potential risk. This practice restricted all of the people who used the service, whether or not there was a current risk to them individually. This was particularly a concern as there was a chance the door would be locked at other times, either intentionally or through oversight as had happened on the day of the inspection. While Deprivation of Liberty Authorisations were in place for people using the service, and these made reference to doors being locked for people's safety, there was insufficient evidence of continual review of this risk. This put people at risk because there was no evidence to support that the measures in place were continuously reviewed to ensure they were the least restrictive option.

During our discussions about this with the registered manager, they told us that the person's needs had not increased as significantly as expected despite the diagnosis given many years ago. There had been no further, similar incidents. They acknowledged that there may be other ways to support people living at the service to be safe at night, especially as waking night staff were on duty every night at the service. They demonstrated that they were open to reassessing this and looking at less restrictive options that may enable people to have access to the kitchen at night whilst managing risks.

Other individualised risk assessments were in place to enable people to be as independent as possible whilst maintaining their safety. They included assessments in relation to issues such as; going out in the community, finance, medicines, specific medical conditions, and participating in specific hobbies. These risk assessments were detailed and regularly updated to ensure they met the current needs of the person.

Where people were unable to tell us if they felt safe we observed their interactions with staff to help us understand. We saw that people appeared comfortable and at ease in the presence of staff, and this led us to believe that they did feel safe. People's relatives were confident that their loved one was safe. One relative who told us they were confident their loved ones as safe said, '[Name] is happy as anything. [They are] always happy to come back to the service.'

Staff had received safeguarding training and were able to tell us about different types of abuse and how they would report any concerns they had. They were sure that the registered manager and the provider would take appropriate action to keep people safe from harm if concerns were raised with them. There was information displayed about how to report safeguarding both within the provider's organisation and to external bodies such as the local authority and the Care Quality Commission.

There were sufficient numbers of appropriately skilled staff on duty to support people safely. Any vacant posts or other staff absences were covered by the provider's own relief staff and agency staff, most of whom knew the people living at the service having worked with them for some time.

Staff had been recruited using robust procedures and all necessary checks, such as references from the previous employer and disclosure and barring (DBS) checks were completed prior to the member of staff starting work.

All the people using the service needed full support to take their medicines and we saw support plans were in place to assist staff to know how to do this. People's medicines were stored in appropriate locked cabinets in their bedrooms. We looked at the Medicines Administration Records (MAR) for two people who used the service and these were completed correctly with no unexplained gaps. Regular audits of medicines management were undertaken to ensure the providers medicines policy and processes were followed and that errors in administration and stock management were identified quickly should they occur.

Relatives told us the service was always clean and well presented, which confirmed our observations on the day of the inspection. People were protected from the risk of infection because staff followed current guidance on good practice in relation to infection prevention and control. We saw there were plenty of gloves and aprons and staff were seen to use these appropriately to minimise the risk of cross contamination. Colour coded mops and buckets and chopping boards were in place and we observed staff changing aprons and gloves before moving onto another activity.

Records showed that the service had carried out all the relevant health and safety checks such as gas safety, electrical and fire systems. All water safety and temperature checks were carried out to monitor and reduce the risks of Legionella and of people being scalded by hot water.

We saw that incidents and accidents were reported and investigated appropriately. Action plans were put in place by the management team to reduce the risk of similar incidents happening in the future. The provider had a system in place to support managers to analyse incidents and to identify trends and patterns and causes of incidents. This showed that that lessons were learned when things went wrong and improvements were made to the care people received as a result.

Is the service effective?

Our findings

People's needs had been assessed prior to coming to live at the service. The provider's systems and processes were designed to ensure their care and support was delivered in line with current standards and evidence-based guidance, such as 'Registering the Right Support'. 'Registering the Right Support' values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service should be able to live as ordinary a life as any citizen. Care and Support was reviewed and updated as people's needs changed, and appropriate referrals to external health and social care services were made as necessary to ensure people's needs were met effectively.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff demonstrated an awareness of their responsibilities under the Mental Capacity Act and care records reflected the level of capacity people had in relation to various specific aspects of their care. Where people lacked capacity, decisions were made on their behalf in their best interests. We saw that staff took time to support people to make decisions and used communication aids, such as pictures, and objects of reference to support them to understand the decision they were being asked to make.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We saw from records that DoLS authorisations had been applied for as appropriate.

People's relatives told us staff had the skills and knowledge of people to support them well. One relative told us the provider ensured staff received additional training when their loved one's needs changed to ensure they had the skills to provide the right support. Staff told us they received training that supported them to do their job well and our observations and review of records supported this.

Training records showed that staff undertook training related to the specific needs of people using the service such as epilepsy, positive behaviour management, and dementia awareness. This was in addition to training such as safeguarding people from abuse, moving and handling people, first aid, food hygiene, fire safety and health and safety.

Staff told us they received regular one to one supervisions and an annual appraisal. They confirmed that they were supported to develop within their role and that there were opportunities to complete qualifications to support their career progression.

People were supported to have enough to eat and drink and to make choices about their meals. Relatives confirmed that the quality of food provided to people was good. During the inspection we noted that staff offered people a choice of lunch using a method of communication suitable to the person. We saw that

people responded positively to this, and clearly enjoyed the food they ate.

Staff told us that people decided what they wanted to eat through a range of communication aids, such as pictures and objects of reference to enable them to understand the choices they were being asked to make. Staff told us that if people did not like a meal on any given day, they could select and were supported to have an alternative.

Staff supported people to access additional healthcare when required. Within care records we saw they had been referred to external professionals in a timely manner and staff had accompanied them to a variety of appointments, including dentists, GPs and specialist outpatient clinics. Each person had detailed health action plans that identified their health needs and how these were to be met.

The premises were accessible and suitable for people's needs. Corridors and rooms were wide enough for wheelchairs and hoists if required and there was level access to a garden area. The communal areas of the service were pleasantly decorated and comfortably furnished. People's bedrooms were personalised to their tastes.

Is the service caring?

Our findings

Relatives told us that the staff were caring and one said, "It is excellent. [Name] gets to do what [they] want to do." Another relative said, "It's really good. [Name] loves it there." People were unable to tell us about their experiences of the service, so we observed the support they received and the engagement between them and staff to help us understand. Staff supported people in a calm and kind manner, which showed respect towards them and it was clear that people felt at ease in their company.

Staff communicated well with people, and clearly understood how each person needed to be supported to make decisions. They used a variety of methods to support communication, such as signs and gestures, pictures, objects of references and short simple questions. They took time and communicated at a pace that supported people to make choices as much as possible.

The registered manager told us that some families were involved in their loved one's care and support but that an advocacy service was available for anyone who may need it. Relatives confirmed they felt involved and were able to give their views about their loved one's care.

We observed people being treated with privacy, dignity and respect. Staff knocked on people's bedroom doors and waited to be invited in. Staff involved people in conversations rather than talking to each other. Staff told us that they supported people with personal care in a discreet manner, making sure their privacy was maintained, and they were as covered as possible at all times.

Staff understood their role and promoted people's independence. Where people needed assistance, staff offered it in a natural and low key manner. A member of staff said, "We support people to do as much for themselves as they can."

Staff supported people to maintain relationships with friends and family where this was important to them. One relative told us they found it difficult to travel to the service so the staff supported the person to visit them instead.

Is the service responsive?

Our findings

Within people's care records was brief information regarding the person's wishes for their end of life care and funeral wishes. However, this information was more than 10 years old in some instances and people's needs and preferences may have changed in this time. The provider had introduced a new end of life support plan document which was very detailed and in an accessible format. The registered manager told us that they were aware this part of people's support plan needed updating and that they would address this as a priority.

The provider had a complaints policy and processes in place to support people to make complaints. Staff confirmed they would support people to make complaints if they wished to. Within people's support plans there was detailed information about how each individual communicated complaints. This included changes in body language, mood and behaviours that may show the person was dissatisfied. However, we saw no evidence that the information in support plans had been used to understand when people were making a complaint. No complaints made by people in the ways described were recorded in the formal complaints log.

Records showed that people had been involved as much as possible in planning their support. Where people were not able to be involved in this process the reasons for this was clearly recorded, particularly where a person lacked the capacity to understand their support plan. In these circumstances it was recorded that the support plan had been written in their best interests. Relatives confirmed they were involved in this process.

Support plans were very detailed and reflected people's needs and preferences and were updated when people's needs changed. However, some of the documents looked at would have benefitted from full review as they were written several years ago. Each aspect of support included guidance about what the person was able to do for themselves and what degree of support they required. Support Plans contained communication profiles that gave clear information to staff about how the person communicated their needs and how staff could make themselves understood. These profiles included guidance such as taking time, being patient, using only two key words at a time, standing face to face, rather than to the side of the person.

We saw that staff knew people well and adapted their communication and working style to meet people's individual needs. For example, one person used their own gestures and signs to communicate their needs. Staff had learned what these signs and gestures meant to enable them to communicate effectively with the person.

Relatives told us that the service met their family member's individual needs well. One relative told us that the service had provided 24 hour support for their family member when they were admitted to hospital to ensure they were able to cope with the experience and that their support needs were met. Additional staff were also provided to meet their needs when they returned home from hospital. This showed that the service was flexible and responded when people's changed.

People were supported to follow their interests. Most people went to a day service during the week where they participated in activities such as horse riding, exploring the countryside and cooking. Most people had at least one day a week at home where they participated in tasks such as laundry and cleaning their room, but also had support to go out to places they enjoyed. People also had opportunities to follow their interests away from the day service. One person had a keen interest in James Bond and was supported to pursue this. Another person collected postcards and staff had made an eye-catching display board for them to show their collection. People had also been supported to grow fruit in the garden that they could then have to eat.

Is the service well-led?

Our findings

The provider showed a strong awareness of current guidance in relation to good practice in services for people with learning disabilities. The recent paper "Registering the Right support" is clear that the values that underpin a good service are choice, independence and inclusion; that people with learning disabilities and autism have the same rights to an ordinary life as all citizens. Although the provider promoted a person-centred culture in line with this guidance, and systems were available to support and encourage this, opportunities to show evidence of this were sometimes missed in the service.

It was clear from our observations that there were positive outcomes for people using the service and engagement with staff was good. However, daily logs did not capture this and tended towards detailing tasks that had been completed, rather than the experiences and achievements of the people who were living at the service. This was a missed opportunity for staff to see the positive outcomes of their work, and also, to put on record the achievements of people on a day to day basis.

Restricting access to the kitchen for all people who lived at the service without regular reassessment of the risks did not support a person-centred culture at the service. Whilst this measure had successfully reduced the risk of people coming to harm, it had also restricted access to part of their home at certain times of day. This had continued for many years without robust checks being made to ensure it was necessary, and the least restrictive way to manage any identified risk.

People were supported to provide feedback on the service through a number of means including surveys and care reviews. However, the surveys we looked at were completed by staff members on behalf of the person and there was no sense that people had been meaningfully involved in this process. The manager was also unable to show us how the results from these surveys were analysed in order to improve the service. The registered manager said they would consider ways to support people to share their views that would provide more meaningful information to support improvements to the service. After the inspection the provider sent us an analysis document and an action plan which demonstrated that this information had been used to make improvements to the service.

Some records relating to people's support, such as support plans, risk assessments and guidelines had not been fully rewritten for many years, and where changes had taken place, these had been handwritten. Although the content of the records were individualised and person centred, there was little evidence to show how the service had a positive impact on people over time, because it looked as if little had changed for people in many years. The lack of full review of people's support needs can lead to people being at risk of receiving unsafe or inappropriate care because information is not analysed to ensure it is still relevant. The locked kitchen door is an example of how practice can become stuck if not regularly challenged. The impact of this on people is that they do not have access to opportunities and personal achievements that they might have if services regularly analyse and challenge the support they provide.

The provider had systems in place to assess and monitor the quality of the support provided. A number of quality audits were carried out on a regular basis to assess the quality of the service and to support

continuous improvement. There were regular visits made by the provider's regional managers to check on the quality of the service and action was taken to make improvements when issues were identified. However, we found that these monitoring checks were not always robust enough, and issues such as reviewing restrictive practices and the maintenance and updating of support plans and risk assessments had not been identified or acted on.

Staff we spoke with were clear about their role and responsibilities and had a good understanding of the provider's values, talking with enthusiasm about their role in supporting people to take control of their lives.

Relatives told us that communication from the service was good. They said, "They always ring me when something happens especially around healthcare so that we can discuss it." They felt the registered manager was approachable and responsive. One relative said, "The manager is marvellous; very approachable and available to talk all the time." Another relative said, "The manager is great. She will always ring me to see how I am doing and let me know what is happening."

Staff meetings took place on a regular basis and staff told us they had the opportunity to contribute to discussions and to share their views about the service and how improvements could be made. Staff were positive about the support they received from the management team and the provider. All the staff we spoke with told us the management team were approachable and they were confident that they would listen to any concerns they raised and take appropriate action.

The registered manager told us, and records confirmed, that the home worked in partnership with other key agencies and organisations such as the local authority, hospitals and other health professionals to ensure the provision of joined-up care.