Turning Point

Turning Point - 1 Hamilton Road

Inspection report

1 Hamilton Road
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22 June 2018

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
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 was the first inspection of 1 Hamilton Road since the current provider took over the running of the service in March 2017. The inspection took place on 15 and 22 June 2018 and was unannounced.

1 Hamilton Road is a 'care home'. People in care homes receive accommodation and their care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

1 Hamilton Road accommodates two people in one adapted building, each person having a separate flat with adapted facilities.

The care service has largely been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. More work was needed to promote these values including choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Records relating to premises and equipment safety checks were not all complete.

Staff had not been receiving appropriate support and supervision to carry out their role working with people with complex needs. Supervisions and team meetings were now being scheduled.

Monthly reviews had not been taking place in line with the provider's policy and were to be re-started.

We have recommended that the provider continues to review the current levels of staff support to ensure both people who use the service receive person centred care and support.

There had been a lack of management stability, which had affected staff morale. Staff we spoke with did not feel informed or that they were listened to and were unsure about some of the management arrangements currently in place.

Quality assurance processes were insufficient to identify and address shortfalls in the service. Action plans were now beginning to be developed to address areas where improvement was needed. An external quality assessor had been commissioned to provide support with this.

Staff understood how to keep people safe and their responsibilities for reporting accidents, incidents or

concerns. Staff demonstrated knowledge of people's support and risk management plans.

There was a programme of initial and refresher training for staff. There had been a lapse in some staff training and competency assessments. Further training and workshops were now being booked.

The service had been recruiting new staff and using agency staff in the interim. The provider was funding specific training for the agency staff to enable them to be effective members of the support team.

Recruitment practices were safe and relevant checks had been completed before staff worked in the service unsupervised.

People's medicines were stored and managed so that they received them safely.

The service took account of people's mental capacity and consent.

People were supported to eat and drink enough to meet their needs.

People received regular and on-going health checks and support to attend appointments. People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals.

Overall the design and layout of the premises met people's needs.

There was a core group of staff who knew the people they supported well and had developed positive caring relationships with them. People were treated with dignity and respect.

People were encouraged and supported to make decisions about their care and support and staff tried to promote people's independence wherever possible.

People were supported to maintain relationships with people important to them.

Care plans recorded people's individual preferences and the core group of long-term staff knew people well.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

Records relating to premises and equipment safety checks were not all complete.

Staff competency checks relating to medicines management had lapsed and was being re-instated.

Staff understood how to keep people safe and their responsibilities for reporting accidents, incidents or concerns.

The home environment was clean and staff were equipped with appropriate personal protective equipment.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not been receiving appropriate support and supervision to carry out their role working with people with complex needs.

There was a programme of staff training. The provider was funding specific training for agency staff to enable them to be effective members of the support team.

The service took account of people's mental capacity and consent.

People were supported to eat and drink enough to meet their needs.

People received regular and on-going health checks and support to attend appointments.

Is the service caring?

Good

The service was caring.

The regular staff knew the people they supported well and had developed positive caring relationships with them.

Staff respected people's privacy and protected their dignity.

Staff involved people in decisions about their care and support. People were supported to maintain relationships with people important to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The systems of support did not always ensure that both people who use the service received person centred care and support.

Monthly reviews had not been taking place in line with the provider's policy and were to be re-started.

Regular staff knew and understood people's care and support needs and how to meet them.

There was a system and procedure to record and respond to any concerns or complaints about the service.

Is the service well-led?

Requires Improvement

The service was not always well led.

There had been a lack of management stability. Staff did not all feel informed or that they were listened to.

Quality assurance processes were not always effective in identifying and addressing shortfalls in the service.

The area manager demonstrated an understanding of the performance of, and challenges within, the service and expressed a commitment to driving improvements within the service.

Turning Point - 1 Hamilton Road

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 15 and 22 June 2018 and was unannounced. The inspection was carried out by one inspector.

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 the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

During the inspection we met the two people who used the service. We spoke with the interim manager, the area manager, a senior support worker and four support workers. We looked at a range of documents including care records, risk assessments and medicine charts for both people who live at the home, staff recruitment, rotas and training records. We also looked at information regarding the arrangements for monitoring the quality and safety of the service provided within the home.

Before and following the inspection, we sought feedback from seven health and social care professionals / agencies about the care provided at 1 Hamilton Road. One of these provided feedback.

Requires Improvement

Is the service safe?

Our findings

Records relating to safety checks and risk management were not all complete or easy to access. The report of a provider health and safety audit carried out in April 2017 listed a number of actions that needed to be completed without delay. These included obtaining up to date inspection and test certificates for fire alarm, fire fighting equipment and emergency lighting, gas safety and electrical installation. It was not evident within the record what actions were taken following the audit. The area manager obtained a copy of an action plan dated July 2017, which provided some evidence of initial actions taken such as contacting the housing provider, but which lacked any record showing if and when actions were completed. A log was kept regarding any maintenance issues. The last entries in the fire safety log book were dated May 2017. Managers and staff told us a new record may have been started in another file, but were unable to locate this.

This is a breach of Regulation 12(2)(d)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The fire extinguishers had been recently checked and labelled with the date when the next inspection was due.

Staff understood how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. Staff received training in safeguarding adults and demonstrated understanding of the policies and procedures for safeguarding and whistleblowing, which provided guidance on how to report concerns.

People's records showed that they were supported to take planned risks to promote their independence and staff were provided with appropriate information on how to manage these risks. Staff we spoke with demonstrated knowledge and understanding of people's support and risk management plans, including when accessing the community. Staff were able to tell us about the risks associated with certain situations and people, demonstrating they knew people well.

Occasionally people became upset, anxious or emotional. Staff demonstrated their knowledge of people's behavioural support plans and appropriate action such as redirecting a person to other activities. Staff had received training in responding positively to people's individual behaviours and were provided with protective clothing, such as bite guards and zipped sweatshirts that could be removed easily if grabbed. Specific physical interventions were monitored, recorded and reviewed.

The rota was planned and staff deployed to provide support to each person with their individual daily living needs and activities, within their individual flats and out in the community. For one person this meant three staff in the mornings, two staff in the afternoons, one staff on a middle shift (12:00 to 19:30) and two staff at night. For the other person there were two staff on each of the morning and afternoon shifts and one staff at night.

The service had been recruiting new staff and using agency staff in the interim, working alongside

experienced staff. A staggered approach was taken to introducing new staff to people in the home, as this needed to be done gradually to meet people's needs. The same agency staff were deployed whenever possible to promote consistency. The provider was funding specific training for the agency staff, who then shadowed regular staff on shift for a period.

There was evidence that lessons were learned and improvements made when things went wrong. The service had notified us about an incident when the home was left with unsafe staffing levels for 45 minutes. Action was subsequently taken to learn from the incident and to minimise the risk of it happening again. A risk assessment was on file in relation to minimum staffing levels and stated that in the event of falling below these, staff from a neighbouring supported living service could be called on to provide support.

A system was in place to keep track of and record relevant checks that had been completed for staff who worked in the home. We looked at the records for two members of staff. These included written references, employment histories, and satisfactory Disclosure and Barring Service (DBS) clearance. DBS checks are carried out before potential staff are employed to confirm whether applicants had a criminal record and were barred from working with vulnerable people.

People's medicines were stored and managed so that they received them safely. Up to date records were kept of the receipt and administration of medicines. There were individual support plans in relation to people's medicines, including any associated risks. Guidelines were in place for when prescribed 'as required' (PRN) medicines should be given and a member of staff demonstrated their knowledge of these. Records of support also showed staff had followed the guidelines on two occasions when a person had been at risk of injuring themselves. Staff had used distraction, redirection and calming strategies before offering first and second stage PRN, in line with the person's support plan.

There had been a lapse in training and checking staff competency in medicines management. This process had now been reinstated. The area manager told us medicines reviews were booked for both people and also training for staff in relation to PRN medicines. Twice daily checks were carried out to help ensure any medicines issues or errors were identified and action taken quickly.

A member of staff told us a person had become more alert and conversational following a reduction in their prescribed medicines. The service had implemented an initiative known as STOMP (Stopping the Over Medication of People with Learning Disabilities and/or Autism).

The home was clean and tidy and cleaning materials were kept locked away when not in use. Staff received training in infection prevention and control (IPC) and were equipped with personal protective equipment, such as disposable gloves and aprons, for use when providing personal care and carrying out domestic cleaning tasks.

Requires Improvement

Is the service effective?

Our findings

A health care professional confirmed the service communicated with them and told us staff performed well working with complex individuals.

There was a programme of initial and refresher training to help ensure that staff skills were updated and they worked in accordance with good practice. The training programme included subjects such as safeguarding people, equality and diversity, fire safety, first aid, epilepsy awareness and positive behaviour support. Staff we spoke with were aware of people's support needs and we observed that they interacted with people in a calm and positive manner.

Due to staff shortages the service had relied increasingly on the use of agency staff. However, due to people's specific support needs, it had been identified that the agency staff did not have training in specific subjects to enable them to be effective members of the support team. Recent and ongoing training was now being provided to rectify this and give agency staff the required level of knowledge and skills in a specific form of conflict management and positive behaviour support (PBS). Further training dates for this were planned for July 2018.

Staff had not been receiving supervision, which would have provided them with formal opportunities to discuss their work performance, any training needs, ideas or concerns, and to receive feedback. One member of staff commented that they had not received a debrief following an incident when they felt they had needed this support. Another member of staff told us there had been no staff meetings or supervisions and said "I wonder how (interim manager) was supposed to do that". The interim manager later informed us that staff supervisions and team meetings were now being scheduled.

This is a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). People's capacity to consent to care was considered as part of the care planning process. Where people lacked capacity to make significant decisions for themselves, best interest decisions had been made and documented, following consultation with family members and other professionals. Where necessary restrictions were in place, appropriate authorisation had been obtained and this was documented in people's support plans. DoLS authorisations were in place in relation to use of locked doors, 'as required' (PRN) medication, safety locks on car doors, restricted access to finances and use of physical interventions. Staff received relevant training and showed an understanding of the MCA and the associated DoLS. A health care professional confirmed the service took into account people's mental capacity and consent.

People were supported to eat and drink enough to meet their needs. Each person had an eating and drinking support plan based on their requirements, routines and preferences. Plans included support guidelines for mealtimes and where necessary, speech and language therapy (SALT) assessments had been sought to assist staff to minimise the risk of choking for people who may have difficulty swallowing. Staff used pictures and other methods to help people make choices about what they ate and drank.

A hatchway was fitted between the kitchen and dining room so that a person could watch their meals being prepared and cooked, as they liked to do. While it was not safe for the person to be in the kitchen at these times, this was an important part of the mealtime experience for them. The person had different coloured plates for breakfast, lunch and dinner that helped to orientate them to what time of day it was.

A health care professional confirmed people were supported to maintain good health. People's records showed they received regular and on-going health checks and support to attend appointments. People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. Staff had contacted a dentist who visited the person because of a possible tooth infection. Following this anti-biotic medicines were prescribed and collected and the changes communicated to the staff team. Staff recorded all contacts and visits from health professionals in people's care records and followed up any appointments where required. There were scheduled reviews of the medicines people were prescribed.

The home provided people with a secure, low stimulus environment to meet their needs and preferences. Staff had been supporting people to gradually introduce more objects into their living space if they wished. One person's en-suite bathroom had problems with recurrent mould and insufficient extraction systems. The bathroom had previously been closed off to enable emergency repairs to be carried out to make it safe. The bathroom had been deep cleaned and the mould professionally treated by the estates department. The service was continuing to work in partnership with the estates department to identify a long term solution.

Good

Is the service caring?

Our findings

There was a core group of staff who knew the people they supported well and had developed positive caring relationships with them. Staff communicated with people using their preferred method and took time to listen and act on what people wanted. Sometimes a person found it difficult to make their needs known. Staff were patient and supported them using pictures, objects of reference, observing facial expressions and body language and enabling the person to take them and show them what they were trying to communicate.

People's care and support plans included guidance to assist staff to involve the person and help them with everyday decisions. For example, how best to present information and ways to help the person understand. The records showed staff spent time with people, involving them in decisions about their activities, daily living tasks and care, with support from families or advocacy. People were supported to maintain relationships with people important to them. Relatives were able to visit their family member at any time of day and there were no restrictions in place. A person had a detailed support plan in relation to receiving visits from a relative. The plan showed how the service actively supported the person and their relative to maintain their relationship.

Staff respected people's privacy and protected their dignity. Staff spoke about people in a respectful manner and demonstrated understanding of their individual needs. Staff were knowledgeable about people's preferences and what mattered to them, enabling them to communicate positively and valuing the person. People's care and support plans were written in a respectful way that promoted people's dignity and independence.

People were supported to have an end of life care plan so that staff knew their wishes and would be able to support the person to have a comfortable and dignified death, ensure that their wishes were carried out and support their family/friends with their loss.

Requires Improvement

Is the service responsive?

Our findings

Care plans were written in a personalised way, including what and who was important to the person. People had communication boards in their flats and staff used picture symbols to assist communication. Staff demonstrated knowledge and understanding of people's care and support needs and how to meet them. They were consistent in what they told us about how individuals communicated their needs and wishes and the methods for supporting them. Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored.

Staff told us how they had supported a person who was now able to take part in more activities within their home, such as helping to decorate a Christmas tree. The person was also accepting more objects being introduced into their flat, including a lightweight dining table and chairs, which previously they would not have done. Staff commented that this was achieved by working with the person "at his own pace".

A member of staff told us they were concerned that one person did not go out as much as they used to. A record showed the person had last gone out ten days ago. The person required three staff to support them when going out in the car. The member of staff said they were worried that when staff cover was short then support was taken from the middle shift allocated to the person for going out. During our visit a member of staff did not turn up for the afternoon shift and, as cover at short notice was not available, a member of staff was taken from the middle shift and allocated to the other person who used the service. Another member of staff confirmed that this was not unusual.

A senior member of staff told us the person regularly declined to go out for a drive. The person was not able to go out in the mornings as this required three staff and they were only funded for two staff during these times. The middle shift had been introduced to provide support for community activities. Staff supporting the person to go out needed to have received specific positive behavioural support training at level three. The interim manager confirmed "The middle shift is first to go if there's a staff shortage. The middle shift is also for (person's name) shopping and cleaning". There had also been an issue with the person's transport, which was being addressed. The area manager told us they were aware of the situation with this person and were looking into accessing further funding to address this.

The Provider Information Return (PIR), which we received in February 2018, stated: 'We will be liaising with Commissioners and CCG to assess the support and reiterate the accommodation needs that each person requires. We will be working to ensure all people are assessed for the correct amount of support to ensure that all their needs are met to a high standard'.

We recommend the provider continues to review the current levels of staff support to ensure both people who use the service receive person centred care and support.

The area manager told us that monthly well being reviews were supposed to be held however these had not been continued by the interim manager. The area manager said these would be re-started. The interim

manager said internal reviews of people's care had taken place. The service was "Looking at ways to go forward, but the need has been to get in enough of the right staff, before we can move forward. The additional staff and training will have an impact".

The provider had a complaints procedure. The interim manager confirmed they had received no complaints relating to people's care and support. Staff understood people's needs well and demonstrated how they would be able to tell if a person was not happy about something, which meant that people would be supported to express any concerns.

Requires Improvement

Is the service well-led?

Our findings

The new provider took over the service on 8 March 2017. Since that time, two registered managers had left the service. The service had been without a registered manager since 15 May 2018.

The interim manager was not available on the day of our inspection. When we arrived we asked who was the person in charge and were told "We are all support workers". There was some uncertainty among staff on duty about the on-call system. Staff spoke on the phone with the interim manager and the recently appointed area manager then came to the home.

The interim manager had commenced their role in May 2018 and the provider had been advertising for a registered manager to cover this service and two supported living services. The area manager said she would now be applying for registration. The area manager told us the interim manager spent five days a week in the office within the home.

The area manager confirmed that some management tasks within the service had not been kept up to date or completed within timeframes, including staff supervision meetings. They told us the provider recognised the need to support staff and that a team manager had now been appointed to provide management support across three services.

Staff told us there had been a lot of restructuring of management. They said they felt this had put more workload pressure on the interim manager, who had come into a difficult situation and not been given enough time and support to get to know the people and services they were trying to lead. They said the transition between providers had not been smooth and no-one came to explain the situation. They had seen the area manager once or twice, who was also new to the company and services. They told us "There were supposed to be people coming in to help transition to new systems. I think the provider got caught up with other things, other services, so it didn't happen".

There had been a lapse in staff training and competency assessments. Training and workshops were now being booked and competency assessments such as for administering medicines were taking place. Between our inspection visits the area manager sent us copies of the staff training matrix and skills updates for regular agency workers.

Quality assurance processes were insufficient to identify and address shortfalls in the service. The area manager confirmed that checks and audits should be carried out by the manager but it was not clear if these had always been done. The area manager had scheduled an audit against key performance indicators across the three services they oversaw. Action plans were beginning to be developed to address areas where improvement was needed. The provider had identified that further work was required to bring people's support plans up to date. An external quality assessor had been commissioned to work with staff on this task.

The area manager acknowledged there had been a lack of management stability, which the provider had

recognised and taken measures to address. Audits were now being done by a quality assessor. The quality assessor had been coming in on three days a week for the past four to five weeks. A locality manager meeting took place each month in Salisbury.

We spoke with the interim manager on the second day of our inspection and they informed us they had given their notice. This they said was due to the workload and changing remit / goals. They spoke positively about the staff team for the quality of care they provided to people. They told us senior managers had visited the service to talk about service plans and changes and the organisation's trainer had been supportive.

The interim manager said "So many changes have to be made", and told us the company were trying to resolve matters, fast tracking recruitment and putting training in place. "It has been tough. However, they have listened, put some people in who can support". They told us "When the previous registered managers left, a lot of knowledge and background information went also. Both had known the services a long time". The interim manager said she wanted to focus on people, however "The focus has been on paperwork that won't last a week; and it's overwhelming. Rolling change on a daily basis. It's a big black hole I can't backfill". They said there was "So much to learn to do, which has not been shown".

Staff were unsure about where some records were kept and what to look for. A member of staff told us "There used to be one file, now there are lots. We don't know where things are". They said they had not had supervision and felt there was a lack of leadership. They said they did not feel they could ask things of the interim manager who was overwhelmed with the workload. They said "I don't feel that all change is bad. I want to feel proud of what we do. The paperwork is not reflecting that. I don't want to feel incompetent". They did not feel they were listened to. There had been no team meetings and a lack of feedback from senior management: "Things get passed up but don't come back down".

This is a breach of Regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider produced a family newsletter. The area manager told us they were working on improving links and communication with people's families.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 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 There was a failure to ensure that the premises and equipment are safe to use. Regulation 12(2)(d)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to operate effective systems and processes to assess and monitor the quality and safety of the service. Regulation 17(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was a failure to ensure that staff received appropriate support and supervision to enable them to carry out their duties. Regulation 18(2)(a)