Truecare Group Limited

Winton Lodge

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 22 and 23 February 2016 and was unannounced. The service was first registered in November 2015 and this was our first inspection. Whilst the service had only been open a short time, we had received information of concern relating to people's safety and to the skills and knowledge of staff. We found that the service was working to address the issues that had arisen.

The service is a care home for up to nine adults and teenagers with learning disabilities who also experience mental health difficulties and may behave in a way that is challenging to others. When we inspected, there were four adults living there and a further person was in hospital.

The service had 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.

People felt safe. They were supported by staff who understood their responsibilities as regards safeguarding adults. Staff felt well supported and were confident that the registered manager would take any concern they reported seriously.

People were treated with compassion and kindness by staff who were getting to know them and who prioritised their needs.

People received care and support to address their individual needs. Their independence was encouraged as much as possible and they were supported to take part in activities at home and out in the community.

At times people became upset, anxious or emotional, or behaved in a way that was challenging for others to cope with. Risks this presented had been assessed and positive behaviour support plans had been developed. These plans were detailed, specific to the person, and emphasised that the least restrictive possible measures should be taken.

Whilst there were enough skilled staff on duty to meet people's needs, it was difficult for staff to attend to all aspects of their roles within their paid shifts. Because staff spent much of their time allocated to one-to-one support, they had little time to attend to non-contact tasks such as writing notes.

We identified two breaches of the Regulations.

There was a risk that people's rights would not be protected because staff did not always follow the requirements of the MCA relating to the deprivation of liberty safeguards. A person had been stopped from leaving the home against their will yet this deprivation of liberty had not been authorised as required by the Mental Capacity Act 2005.

People's consent to care, including restrictions that were in place to keep them safe, had not always been recorded. Where people had not given consent, there was no record of mental capacity assessments and best interests decisions in line with the Mental Capacity Act 2005.

You can see what action we told the provider to take at the back of the full version of the report.

We recommended the provider reviews their arrangements for training staff in similar new services in mental health to ensure staff have the skills they need when people start using the service. It had been over two months from when the home opened before all staff had received training in mental health and the skills needed to deal with behaviour that challenges others.

We also recommended that the provider keeps their staffing levels under review so that they can continue to ensure people's safety and meet their needs.

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 at the point of the inspection was safe.

There had been a delay in ensuring that all staff were trained in mental health awareness, so that they knew how to support people safely. We have recommended the provider continues to review their arrangements for training staff in new services that specialise in supporting people with mental health difficulties.

There were sufficient staff on duty to provide the support people needed. Staff other than the registered manager were mostly allocated to work one-to-one with people.

People felt safe. Staff understood their responsibilities for safeguarding adults and were familiar with people's positive behaviour support plans.

Is the service effective?

Requires Improvement

The service was not wholly effective.

People were prevented from leaving the service for their own safety but for some people this was not authorised legally, through either their consent or the Deprivation of Liberty Safeguards. The requirements of the Mental Capacity Act 2005 had not been followed in relation to some aspects of people's care.

Staff were supported through training and supervision.

People were supported to maintain their health.

Is the service caring?

Good

The service was caring.

People were treated in a respectful and caring way. Their privacy and dignity were respected.

People were supported by staff who were getting to know them as people and were familiar with the support they needed.

Is the service responsive?

Good

The service was responsive.

People were supported to meet their individual needs.

People took part in a range of activities and were supported to maintain relationships with people important to them.

Complaints were taken seriously and were acted upon.

Is the service well-led?

Good

The service was well led.

The service was new and was beginning to develop a positive, person-centred culture.

There was a quality assurance system in place to oversee the service people received.

People benefited from being supported by staff who were familiar with the organisation's whistleblowing policy and who were confident that the registered manager would take their concerns seriously.

Winton Lodge

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 place on 22 and 23 February 2016 and was unannounced. It was undertaken by two inspectors in response to information of concern relating to staffing, training and care planning.

Before our inspection we reviewed the information we held about the home, including notifications of incidents the provider had sent us. We also spoke with the local authority safeguarding investigation team. We had already asked the provider to complete a Provider Information Return (PIR) but inspected as a matter of urgency before they had had a reasonable opportunity to complete this. A PIR is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with two people who lived in the home. We also spoke with three support staff, the registered manager and their line manager. We observed care and support in communal areas and looked at the care records for two people and medicines administration records for four people. We also looked at records that related to how the home was managed, including four staff files and the provider's quality assurance records.

Good

Is the service safe?

Our findings

People felt safe living at the home. They told us they felt safe with the staff. We observed that people were relaxed in the presence of staff and that they freely approached them to talk with them. One person explained how they always went out with staff, which helped them feel safer as they might otherwise be taken advantage of.

People were protected against the risks of potential abuse. There were safeguarding policies in place for adults and for children, setting out the actions for staff to take if they had concerns that someone was subject to abuse or neglect. Staff were trained in safeguarding adults. The staff we spoke with knew how to identify and report safeguarding concerns, and one worker gave an example of how they had done so. There were procedures in operation for handling, recording and checking people's money. People all had their own bank accounts, with outside representatives rather than staff acting as their appointees. Easy read information about staying safe would have been displayed on the noticeboard in the hall. However, the noticeboard had temporarily been removed following an incident and was awaiting reinstatement.

Staff understood how to keep people safe. Each person's individual risks had been assessed and planned for. At times people became upset, anxious or emotional, or behaved in a way that was challenging for others to cope with. Risks this presented had been assessed and positive behaviour support plans had been developed. These gave strategies for managing behaviours proactively by trying to avoid the circumstances that made the behaviours likely. The plans also set out how staff should respond if people showed signs of agitation and for supporting them if they behaved in a particular way. These plans were detailed, specific to the person, and emphasised that the least restrictive possible measures should be taken. The staff we spoke with were familiar with them.

Prior to the inspection we had received concerns that ligature cutters were not available at the home when people first moved in who may have been at risk of strangling themselves. However, by the time of the inspection ligature cutters had been provided and staff were able to tell us where they were located.

People involved in accidents and incidents were supported to stay safe and action was taken to prevent further injury or harm. Accidents and incidents were recorded. The registered manager reviewed them for contributory factors and whether any additional action was necessary. The numbers and types of accidents were monitored each month for any developing trends. Behavioural incidents were recorded on behaviour observation charts, with any use of physical intervention (safe holding) recorded in a log. Physical intervention had been used only twice by individual staff members as a proportionate response to stop someone hitting out at them. The behaviour observation charts for all but one person were with the provider's psychology team for review.

Prior to the inspection we had received concerns that staff did not all have sufficient training to be able to support people safely, and that people had sometimes missed planned activities because of this. By the time of the inspection there were enough skilled staff on duty to meet people's needs. Day shifts lasted from 7.15am to 2.45pm and from 2.15pm to 9.45pm, with four staff on each shift. At night, between 9.30pm and

7.30am, there were two staff awake on duty and one asleep, who woke if needed. These staff numbers included dedicated one-to-one support for people who required this. The provider calculated staffing levels based on a 'care needs assessment', although the assessment templates did not take into account non face-to-face contact tasks. However, staff told us they spent most of their time allocated to one-to-one support, which made it difficult for them to attend to non-contact tasks such as writing notes or taking a short break to compose themselves if someone became very challenging to support. They said that staff often stayed on after their shift had ended to write notes. The activities organiser was about to become supernumerary to provide more opportunities for people to meet their social needs.

We recommend the provider keeps staffing levels in this new service under review to ensure these continue to ensure people's safety and meet their needs when they are unsettled and are behaving in a way that challenges others.

Whilst staff now had the knowledge and skills they needed to keep people safe, we identified that there had until recently been some issues in relation to the provision of training. Prior to the inspection we received information that indicated staff, many of whom were new to health and social care, did not have any training in mental health.

Staff told us they had the previous week attended a day's mental health training session where they learnt about Mental Health Act 1983 sections, mental health diagnoses and treatments. The registered manager confirmed that most staff had attended a mental health training session shortly before the inspection. However, people with mental health needs had started moving into Winton Lodge at the end of November 2015, nearly three months beforehand.

We recommend the provider keeps their arrangements for training staff in new services that specialise in supporting people with mental health difficulties under review, to ensure staff have the necessary skills and knowledge to fully meet the needs of people, and have an awareness of mental health issues when people start using the service.

The physical intervention system in use was accredited by a nationally respected learning disability organisation. Staff told us they had been trained in using these physical interventions. The registered manager confirmed that apart from three very new staff whose training had been booked, staff had either now completed physical intervention training or were due to attend this during the week of the inspection.

Safe recruitment practices were followed before new staff were employed to work with people. Staff files included application forms, records of interview and appropriate references. Records showed that criminal records checks had been made with the Disclosure and Barring Service to make sure people were suitable to work with people in a care setting.

Peoples' medicines were managed and administered safely. Medicines were stored securely and records were kept so that the amount stored could be accounted for. Most oral medicines were supplied in blister packs, each blister containing the correct dose for a particular time and day, to help ensure people received their medicines as prescribed. Where people were prescribed 'as required' medicines, there were written guidelines for staff setting out what each medicine was for, when the person might need it, the maximum dose in 24 hours and the minimum interval between doses.

Requires Improvement

Is the service effective?

Our findings

People told us they generally liked living at Winton Lodge. One person, who showed us around the house, commented that it was "almost like home" and said, "The beds are really comfortable". People spoke positively about the staff.

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. 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.

There was a risk that people's rights would not be protected because staff did not always follow the requirements of the MCA relating to deprivation of liberty and the Deprivation of Liberty Safeguards. The registered manager had identified two people who they believed were being deprived of their liberty. They had applied to the appropriate supervisory body for this to be authorised under DoLS. One person's deprivation of liberty had already been authorised under DoLS; the authorisation was in date and had no special conditions. The other person's deprivation was due to be assessed very soon. There were no applications to authorise DoLS for the other two people, both of whom were under the constant supervision of staff and were unable to leave the premises unescorted. We reviewed one of these people's files. Staff had assessed that the person was able to understand why they needed to live in the home and was not free to leave. However, the assessment stated that there was no impairment or disturbance in the functioning of the person's mind or brain, despite the person having some degree of learning disability and mental health needs. Additionally, incident records indicated that on at least three occasions the person had withdrawn their consent and attempted to leave. Each time they had been stopped or eventually returned after being encouraged to come back by staff. Depriving the person of their liberty without their consent, if they had the capacity to give this, was unlawful. The person's learning disability and mental health needs meant there may have been grounds at times to question the person's capacity to make this decision, in which case an application for DoLS authorisation would have been necessary. We raised this with the registered manager at the inspection and they informed us they would apply for DoLS to be authorised for both people.

Consent to care, or mental capacity assessments and best interests decisions in line with the MCA, had not always been recorded. The registered manager informed us that people's consent was sought to their care, where they were able to give this. Some people required restrictive measures, such as a locked kitchen, alarms on their bedroom doors and a high level of one-to-one supervision from staff to help keep them safe. The registered manager confirmed that one of these people was able to understand the implications of their care plan and to give consent to different aspects of it, including the restrictive measures. However, the person's care plan did not set out what action staff should take if the person withdrew their consent. In both

people's care records we looked at, consent or mental capacity assessments and best interests decisions had not been documented specifically in relation to the restrictions.

The failure to apply for authorisation to deprive people of their liberty was a breach of Regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The failure to record consent or, where people could not give consent in relation to specific decisions, mental capacity assessments and best interests decisions, was a breach of Regulation 11(1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs were met by staff who had access to the training they needed. Staff told us they had the training they needed to meet people's needs. We viewed staff training records, which confirmed staff received training on a range of subjects. Training was delivered by trainers or by staff watching a DVD and included: safeguarding adults, fire safety, food safety, moving and handling, health and safety, infection control, medicines and the Mental Capacity Act 2005. Before Winton Lodge opened, staff had three weeks' induction which included training, reading policies and shadowing experienced staff in some of the provider's other homes that support a similar client group.

People were supported by staff who were themselves supported through supervision (one-to-one meetings to discuss their work) with the registered manager or an assistant manager. Staff told us they had regular supervision meetings. The registered manager explained that they aimed for staff to have monthly supervision. They noted that some supervision sessions had happened even though not planned when staff had had particular concerns.

People told us they liked the food. They said they were able to make choices about what they had to eat and that they could have an alternative if they did not like what was on the menu. They also explained how they were involved in preparing and clearing up after meals. We observed people using the kitchen under the supervision of staff to prepare drinks and food. There were regular menu planning meetings. Both of the two annexe suites had their own kitchen facilities. Staff told us that people living in the annexe would be supported to choose, shop for and prepare their own food.

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 such as community learning disability staff. People also had access to the provider's psychology service. For example, one person told us spontaneously how they had been experiencing indigestion and were going to see their GP the next day. Another person had complained of a pain and staff had arranged a GP appointment for them. Care records showed that people saw relevant professionals, such as GPs, dentists and, for all people except for one, the local community learning disability team. Health action plans, to describe the support people need to stay healthy, were being developed using templates provided by the local community learning disability team.

Good

Is the service caring?

Our findings

People told us they liked the staff. For example, one person commented, "Most, all of them are alright… it's just me being picky". The atmosphere in the house was relaxed and staff had a good rapport with people.

People were treated with kindness and compassion in their day-to-day care. All the interactions we observed were friendly, respectful and calm, even when people became upset or angry. We observed people spending time in conversation with staff. Staff listened to what people were saying to them and responded promptly when they needed assistance. Staff spoke about people in a way that demonstrated their respect for them.

Although this was a new home, people received care and support from staff who were getting to know them. The registered manager and staff were able to tell us about people's individual preferences, skills and abilities. People's care records included information about their personal circumstances and how they wished to be supported. Staff addressed people by their preferred names.

People were involved in decisions about their care and support. Their views were sought through periodic care reviews and regular meetings with the member of staff who was their key worker. A key worker is a named member of staff that was responsible for ensuring people's care needs were met. There was evidence of people's involvement in their care. For example, a person who was able to read their care plan and risk assessments had done so, and had signed their risk assessments.

People's privacy and dignity was respected. The home was spacious and enabled people to spend time on their own if they wished. A person told us how they had an ensuite bathroom, had a key to their room and could lock their door from the inside. This was the case with all bedrooms. Even though some people had many hours of one-to-one care and support, care plans addressed their need for private time alone in their room.

People were encouraged to be as independent as possible, within the restrictions in place. For example, people explained how they were expected to clean their rooms. A person told us that someone else had prepared the previous day's evening meal and that it would be their turn to cook that evening. Care plans set out what people were able to do for themselves and where they needed staff support.

Good

Is the service responsive?

Our findings

The people we spoke with were positive about living at Winton Lodge and told us they got the support they needed. For example, one person said they liked the home although they sometimes had not wanted to live there when another person was noisy.

Care plans were personalised and detailed daily routines specific to each person. The registered manager and staff we spoke with were familiar with the care and support people needed. The registered manager explained that they had been through care files with all staff to ensure they were aware of people's needs. Care files organised so that it was straightforward to read through assessments, care plans, positive behaviour support plans and records of support given. People's needs had been assessed before they moved into the home. Information had been sought from the person, their relatives and professionals involved in their care. The assessments were used to develop care plans, and people's needs and care plans were kept under review. Care plans reflected people's needs and choices and covered areas such as communication, personal care, daily living and independence skills, activities and sleep.

People were supported to pursue their interests and took part in a range of activities of their choice at home and in the wider community. One person said they enjoyed going out and that staff supported them to do this when they were not involved with other things. Another person told us how staff supported them to go out on cycling trips. The registered manager gave examples of other activities that people did such as swimming, bowling and going to the cinema. They explained that they had linked with the local community learning disability team regarding further options for activities. We observed a person using the house computer to prepare their CV. They told us they had assisted staff to move the computer from the office to a communal area. There was an activities organiser, who up to the inspection had been rostered in the staff numbers to provide care and support but was about to start working specifically to promote activities.

People were supported to be as independent as possible. Care plans set out what people could do independently and where they needed staff to prompt and support them. For example, a person's care plan stated they were independent with their personal care but needed occasional reminders from staff. People told us how staff supported them to undertake daily living tasks such as tidying their room, food shopping, cooking and laundry.

People were encouraged and supported to maintain relationships with people who mattered to them. On the first day of the inspection one person was away visiting their family. Another person's care records showed that they had been in regular contact with some family members.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. There had been two complaints, both verbal, since the service opened. These had been investigated and action had been taken to address the issues.

Good

Is the service well-led?

Our findings

People did not tell us their views on the leadership of the home, although we observed they had a good relationship with the registered manager and the staff on duty.

Although new, the service was developing a positive, person-centred culture. People had opportunities to feed back their views about Winton Lodge and about the support they received, through regular sessions with their key worker and at house meetings. The registered manager had regular contact with people in the house and with staff. Staff felt well supported by the registered manager and their colleagues. Staff meetings had been held in November and December. The registered manager was planning to hold two staff meetings when meetings were due to make it easier for both day and night staff to attend.

People benefited from staff who understood and were confident about using the whistleblowing procedure. Staff had confidence the registered manager would listen to their concerns, which would be received openly and dealt with appropriately.

The service had 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.

The registered manager had notified the Commission about significant events. We use such information to monitor the service and ensure they respond appropriately to keep people safe.

The registered manager said they were able to call for assistance when needed and were supported during the inspection by their line manager. As this was their first post as a registered manager and a deputy manager had yet to be recruited, they were supported two days a week by an experienced manager from another of the provider's homes. There was a vacancy for a deputy manager and recruitment was ongoing.

Quality assurance systems were in place to monitor the service being delivered. Because the home was new, quality assurance surveys of people, relatives and staff had not yet been undertaken, although they were planned for later in the year. There were also arrangements for internal audits such as monitoring visits from managers of other homes.

The home had started to work in partnership with local community learning disability professionals. Staff told us how professionals visited the home regularly and explained how they were beginning to get an understanding of their roles. People had moved to the home from placements further afield, and most had already been referred to the community learning disability team.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Service users' consent was not always recorded; sometimes people received care they had not consented to in order to keep them safe but mental capacity assessments and best interests decisions in relation to this were not recorded. Regulation 11(1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: some service users were deprived of their liberty without lawful authority for the purpose of receiving care and treatment. Regulation 13(5)