

The Brandon Trust

Hunters Green Care home

Inspection report

12 Criftycraft Lane, Churchdown,
Gloucestershire, GL3 2LH
Tel: 01452 859096
Website: www.brandontrust.org

Date of inspection visit: 6 and 7 January 2015
Date of publication: 14/04/2015

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?

Good



Is the service well-led?

Requires improvement



Overall summary

This inspection took place on 6 and 7 January 2015 and was unannounced. Hunters Green Care Home provides accommodation and personal care for four adults with a learning disability or an autistic spectrum condition. Both younger and older adults use the service. Some people were new to the service whilst others had been there for a number of years. The four people living at the home had a range of support needs including help with communication, personal care, moving about and support if they became confused or anxious. Staff support was provided at the home at all times and people required the support of one or more staff away from the home.

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 and associated Regulations about how the service is run.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The evidence was gathered prior to 1 April 2015 when the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 were in force.

Summary of findings

People had decisions made on their behalf that were not fully documented or regularly reviewed to make sure their changing needs and circumstances were addressed. People received the medicines they needed but the recording and storage of medicines did not always comply with best practice. People's immediate health needs were responded to but records kept to help staff manage their ongoing health needs were not being regularly updated. Quality audits had not identified all of the problems within the service and action was not always taken to quickly to address issues identified. You can see what action we told the provider to take at the back of the full version of this report.

People were supported by a caring staff team who knew them well and treated them as individuals. For example, the ways each person communicated their needs and preferences were understood by staff. People were encouraged to make choices and be as independent as possible. In order to achieve this, a balance was struck

between keeping people safe and supporting them to take risks and develop their independence. One relative said, "Staff are all really kind" and "I couldn't wish for [name] to be in a better place".

People had not yet been supported to identify goals they wanted to work towards but they were supported to stay active at home and in the community. Where possible, staff offered activities they knew matched the person's individual preferences and interests.

Staff felt well supported and had the training they needed to provide personalised support to each person. Staff were now meeting with their line manager to discuss their development needs and action was taken when concerns were raised. Learning took place following any incidents to prevent them happening again. Staff understood what they needed to do if they had concerns about the way a person was being treated. Staff were prepared to challenge and address poor care to keep people safe and happy.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe. People received the medicines they needed but the recording and storage of medicines did not always comply with best practice. The risks people faced were assessed but regular review did not take place to make sure changes were taken account of.

People were protected from preventable harm as learning and action took place following any incidents and staff had a good understanding of safeguarding requirements.

Sufficient staff with the relevant skills, experience and character were available to keep people safe and meet their needs. The premises were well maintained and clean.

Requires improvement



Is the service effective?

The service was not always effective. People had decisions made on their behalf that were not fully documented or regularly reviewed to make sure their changing needs and circumstances were addressed.

People's immediate health needs were responded to but records kept to help staff manage their ongoing health needs were not being regularly updated. People were supported to eat a healthy diet by staff.

The training staff needed to support people had been assessed and training was planned to address the gaps identified. Staff now met with their line manager to receive feedback on their practice and discuss development needs.

Requires improvement



Is the service caring?

The service was caring. People were treated with kindness and respect by staff who understood the importance of dignity and confidentiality. One relative said, "Staff are all really kind" and "I couldn't wish for [name] to be in a better place".

People were supported to communicate by staff who knew them well. They were encouraged to make choices and to be as independent as possible. Staff were prepared to challenge and address poor care. Staff showed a passion for supporting everyone in a personalised way.

Good



Is the service responsive?

The service was generally responsive. Support plans recorded people's likes, dislikes and preferences but a few pieces of important information had not been included.

People had not yet been supported to identify goals they wanted to work towards but they were taking part in activities in the home and the community.

Good



Summary of findings

Complaints had been dealt with appropriately in the past and relatives said they would be able to complain if they needed to. Staff monitored people's behaviour to help identify if they were unhappy.

Is the service well-led?

The service was not always well-led. The quality was regularly audited but the audits had not identified problems with the administration of medicines and record keeping found during this inspection. Actions were not always taken in a timely fashion to address shortfalls identified by the audits.

The registered manager was well supported by the provider to manage the service effectively. The provider had clear expectations about the way staff should support people and staff understood and acted in accordance with these expectations. Staff understood their responsibilities and felt able to share concerns with the registered manager.

Requires improvement



Hunters Green Care home

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 6 and 7 January 2015 and was unannounced. An adult social care inspector carried out this inspection.

Before the visit, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service,

what the service does well and improvements they plan to make. We also reviewed previous inspection reports, notifications and enquiries we had received. Services tell us about important events relating to the service they provide using a notification. The local authority also shared a quality assurance visit report completed in November 2014.

During our visits we spoke with the registered manager and four members of staff and a GP who visited the home. We spent time observing the care and interactions between staff and people living at the home. We looked at three support plans, two staff recruitment records, staff training records and a selection of quality monitoring documents. Following the visit we received feedback from two relatives and a social worker.

Is the service safe?

Our findings

Although people received the medicines they needed at the right time, the storage and recording of medicines was not always in line with best practice. For example, there was no recorded date of opening on some liquid medicines and therefore some medicines were potentially being used past their recommended date of disposal. Using medicines past their disposal date could mean that people received medicines that were less effective or unsafe.

Regular checks of the medicines in stock were not taking place to make sure good practice was being followed. Some medicines administered by staff required stricter controls on their storage and recording. Although the correct information was being recorded, this was not being done in a book that met legal requirements. An appropriate book was on order.

Each person had a medicines profile that identified the medicines they were taking and provided staff with information to help them safely administer the medicines. These profiles were not dated so staff did not know how recently they had been reviewed. The medicines on the profile did not always match the medicines on the person's current prescription. This could cause confusion and result in administration errors.

This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each person had a list of homely remedies their GP had agreed staff could administer on their behalf. The list identified how long a homely remedy could be given before consultation with the GP was needed. All staff had been trained to safely administer medicines and they were observed each year to check they were still competent to do so.

The risks people faced were evaluated by staff to identify when a written risk assessment was necessary. Some activities had, however, not been risk assessed in writing. Some people's risk assessments had not been reviewed by staff as often as the company required. This meant a need to change the way risks were managed may not be identified as soon as possible in order to keep people safe.

People's rights to make choices and take risks were reflected in the risk assessments, as was the importance of keeping them safe. Risk assessments were detailed and gave staff clear guidance to follow that matched the content of people's support plans. Some restrictions had been put in place to keep people safe. For example, one person had rails on their bed to prevent them falling out. The reasons for these restrictions were documented in the risk assessments and staff told us about less restrictive alternatives that had been explored.

There was an emergency evacuation procedure for each person that identified the help they would need to safely leave the building in an emergency. The plans did not, however, explain what to do if the person refused to leave. Fire alarms and equipment were regularly tested to ensure they were in working order.

The home was well designed and maintained which contributed to people's safety. People had private space when they wanted to be alone and this was especially important to those people with an autistic spectrum condition. Staff could request maintenance to be undertaken and they said requests were actioned in a timely fashion. Staff had achieved a good balance between a hygienic and a comfortable environment. The cleanliness of the environment was audited annually and actions had been identified as a result, such as the need to purchase pedal bins and provide staff with hand washing training. These actions were being addressed.

People were protected from preventable harm because learning and action took place following any incidents. This reduced the likelihood of similar incidents occurring in the future. Incidents were recorded and reviewed and this resulted in changes to people's risk assessments and support plans. The registered manager and quality manager at head office reviewed all incidents to make sure the necessary actions had been completed before they were signed off.

Staff had access to guidance about safeguarding to help them identify abuse and respond appropriately if it occurred. They told us they had received safeguarding training. Two staff who needed training were already booked on a course. Safeguarding was also discussed at staff meetings and individual supervision meetings. Staff described the correct sequence of actions to follow if they suspected abuse was taking place. They said they would have no hesitation in reporting abuse and were confident

Is the service safe?

the registered manager would act on their concerns. Most people would be unable to verbally communicate if they were being abused so staff monitored their behaviour for unexpected changes that needed following up. Staff also spoke with people's families regularly to see if they had any concerns. Staff were aware of the whistle blowing policy and the option to take concerns to appropriate agencies outside the home if they felt they were not being dealt with effectively.

There were enough staff on duty to meet people's needs and staff had time to sit and talk with people. The number of staff needed for each shift was calculated using the care hours contracted by the local authority. The registered manager confirmed the correct number of staff were on duty for each shift. The majority of the staff team had worked at the service for a number of years and knew the

people they supported well. Recruitment was ongoing to replace two staff who had recently left. In order to maintain consistency for the people living at the home, the registered manager tried to use temporary staff who were already known to people. Agency staff were only used in an emergency.

Safe recruitment procedures ensured people were supported by staff with the appropriate experience and character. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to establish whether the applicant has any convictions that may prevent them working with vulnerable people. Any gaps in an applicant's employment record were followed up to ensure a full history was obtained.

Is the service effective?

Our findings

People's health needs were recorded in their health file, however, the records did not accurately reflect people's current needs and there was an inconsistency in the way in which information was recorded. Files contained paperwork that was no longer current, such as medicine administration records from 2011 and a risk assessment from 2009. Similarly, the file contained a list of medicines each person took but this no longer matched their prescription. Important information about people's health needs was referred to in their support plan but had not been updated in the health file. Different staff were using different systems to record when people needed to attend routine health appointments. There was therefore a risk that staff might not provide the appropriate care for people and that people may miss necessary appointments.

This was in breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's rights under the Mental Capacity Act 2005 (MCA) were not being fully met. The MCA is legislation that provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Some mental capacity assessments and best interest decisions had been completed by staff for decisions they were not qualified to make. For example, decisions about medical interventions and examinations. These decisions should have been made by the responsible clinician with care staff consultation. Making these decisions indicated staff did not fully understand their responsibilities under the MCA. Half of the staff team had not received MCA training. Some staff told us they did not understand the MCA despite having completed the training.

A record should be kept of decisions made on a person's behalf to show their rights have been respected. MCA assessments and best interest decisions had not been documented for each relevant decision. For example, when bed rails were being used and the person could not consent due to a lack of mental capacity. Some mental capacity assessments and best interest decisions had not been reviewed since they were put in place and others had past the most recent review date. This risked changes in the

person's needs and circumstances not being addressed in a timely fashion. The registered manager told us MCA records should be reviewed every three months when the rest of the support plan was checked but this was not happening.

This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The DoLS provide a lawful way to deprive someone of their liberty, provided it is in their own best interests or is necessary to keep them from harm. The registered manager understood when and how an application to deprive someone of their liberty should be made. Proper policies and procedures were in place and were being followed. Applications to deprive people of their liberty had been submitted to the local authority but responses had not yet been received.

Staff told us they did not normally need to use physical interventions to keep people safe. There was, however, a policy in place that detailed how staff should act if they needed to intervene in an emergency. Staff understood their responsibility to act to keep people safe but also to avoid restricting their freedom.

People's immediate health needs were addressed quickly by staff. One person was feeling unwell during our visit. Staff contacted their GP to seek advice and a visit was arranged for that day. Staff also altered the meal plan for that person to encourage them to eat. A GP confirmed staff contacted them promptly with concerns and were knowledgeable about the people they supported. They also said staff followed professional guidance from the community learning disability team and speech and language therapists. A social worker told us staff kept in close contact and shared relevant feedback and highlighted concerns in a timely fashion.

All staff had met with their line manager in the last three months to discuss their performance and training needs. They also discussed the needs of the people they worked closely with. These meetings had not taken place regularly in the past and the registered manager told us this would be addressed by ensuring six meetings took place for each member of staff per year. A structure had been introduced

Is the service effective?

for these meetings to make sure they covered relevant topics and issues from previous meetings were followed up. Using these meetings, the registered manager had identified that some staff lacked knowledge of company procedures and this was being addressed to make sure people received the best possible care. Annual appraisals were scheduled for January 2015. There were no records of appraisals having taken place since 2012.

People were supported by staff who had received training specific to their needs. For example, staff had completed training to support people at the end of their life and around dementia. Staff told us they felt competent and could ask for additional training when they needed it. Some staff had not completed training in infection control, health and safety, fire safety and safeguarding. Some had now been booked on training and the registered manager had put a plan in place to address the remaining gaps. A social care professional told us staff seemed enthusiastic about developing their knowledge of how to support younger people after two younger people began using the service. Staff meetings also helped to improve practice. These meetings were taking place every two months. During recent meetings the registered manager had

highlighted areas of good and poor performance to encourage improvement. He had also given staff updates on people's needs and local procedures. This helped to ensure all staff were following a consistent approach.

People were offered a healthy diet and appeared to enjoy the food prepared for them. Most people could not express their preferences verbally so staff monitored their response to the food prepared to make sure they were enjoying it. People's nutrition and hydration needs were recorded in a healthy eating file. This file made it clear staff should respect people's choices about eating and drinking. Staff told us they avoided buying low quality food and tried to ensure people had a varied and healthy diet. A weekly menu included recipes to help staff cook the planned meals. Staff told us alternatives to the menu could be provided if people did not want to eat what was planned. Two people had guidance in place from a speech and language therapist as they needed a specific food texture and seating position to help them eat safely. Staff were following these guidelines. One relative told us staff monitored the person's weight to make sure they were eating enough.

Is the service caring?

Our findings

There was a friendly atmosphere in the home and staff behaved in a caring and professional manner. Staff showed a passion for supporting everyone in a personalised way. People looked comfortable with the staff supporting them and chose to spend time in their company. One relative said, “Staff are all really kind” and “I couldn’t wish for [name] to be in a better place”. One social worker said some staff had developed a really positive relationship with the person they had been to visit.

Staff had detailed knowledge about the people living at Hunters Green Care Home. They used this knowledge to care for people in a way that met their individual preferences and needs. Staff explained what could upset people, what helped them stay calm and what people were interested in. This closely matched what was recorded in people’s support plans. We saw staff applying this knowledge during our visit. For example, one person’s mood was visibly lifted when staff gave them an object of significance to them. One relative said, “Staff have done really well to understand [name] as well as they do”.

People were spoken with in a patient and caring manner by staff. They talked with people about topics of general interest that did not just focus on the person’s care needs. They also used physical contact to reassure people. Staff understood the different methods people used to communicate and gave them time to express themselves. Staff shared information with people about what was happening in a way they could understand.

People were encouraged to make choices, for example about what they drank or when they got up and went to bed. Staff patiently explained choices to people and then waited for a response. Staff told us people had not got any specific spiritual or cultural needs. This had been checked with people’s families where the person was unable to communicate verbally. People were also encouraged to be as independent as possible. For example, staff encouraged one person to feed themselves and only intervened when the person indicated they wanted help.

Before staff were recruited, they met people using the service. This allowed the current staff to evaluate how people responded to the applicant prior to making an offer of employment. When people were unable to express views about their support, staff sought input from relatives and professionals. Staff described how they had consulted relatives about the best way to support people and how they valued the detailed knowledge some relatives had. One relative told us they felt very involved in the person’s care as their views were regularly sought and they were always invited to relevant meetings. Staff had requested for an advocate for one person who had no family. It had not been possible to arrange an advocate so staff had consulted with other professionals and made a decision in the person’s best interests.

Staff were aware of the need to protect people’s dignity, particularly whilst helping them with personal care. Support plans contained practical guidance, such as reminding staff to cover people with a towel whilst they were being washed. The staff team had signed up to a national campaign to improve dignity in care. As a result, the registered manager received newsletters that focussed on making improvements in the way people were supported. He was working to identify areas for improvement within the service. Staff ensured people had privacy when they wanted it and were careful to hold confidential conversations away from other people. Care records were stored securely to make sure people’s personal information was kept confidential. Staff always spoke about people and to people in a respectful way.

The risk of people experiencing poor care was reduced as staff and the registered manager were prepared to address problems as they arose. For example, a member of staff had been supported to improve the way they communicated with people as a result of feedback to the registered manager from others. Staff were observed by senior staff on an ongoing basis to ensure good practice was followed. They received feedback to help them improve the way they worked with people.

Is the service responsive?

Our findings

People were not currently being supported to work towards goals that reflected their wishes and aspirations. The registered manager was arranging person centred planning meetings for each person to identify their priorities and goals for the future. In the meantime, people's care plans contained some development goals that had been set for them in the past, such as using a spoon to eat and walking more. The goals in people's support plans were past their review date and there was little record of any progress against them. Some goals were written in a way that would help staff support people to achieve the goals but others lacked any practical detail. Despite the lack of formal goals, staff still supported people to do things important to them such as meeting with family members.

People's support needs and their support plans were reviewed every three months. This included looking at activities that had gone well, reviewing any changes in the person's behaviour and recording changes in their needs, medicines and health. Despite these reviews, we found a few examples of important information, such as a new disability, not being reflected in people's support plans. Staff talked knowledgeably about the changes in people's needs but they had not been recorded. People's changing needs were discussed by staff at a handover meeting between each shift. These meetings were now documented to prevent important information being lost. This had been in response to feedback from health care professionals and family members. A diary was used to make sure all staff knew the tasks they were responsible for during their shift.

Each person using the service had a support plan which was personal to them. This was initially produced using information from professionals and family members who knew the person well. Staff got to know each person and the support provided was built around their unique needs. Staff monitored how people responded to different

situations and used this to build up a picture of their likes and dislikes. Each support plan recorded who had contributed to the plan and how involved the person concerned had been.

Support plans included information on maintaining people's health, their daily routines and how to support them emotionally. It was clear what the person could do themselves and the support they needed. There was a lot of detail included for those people who could not easily express their preferences. Where people could become very anxious, there was clear information about how to support them to manage their anxiety. We observed staff using these techniques. Assessments of how people showed pain or distress helped staff to recognise when people needed additional support. Support plans also detailed how each person communicated. This included listing what different movements or sounds could mean.

People were supported to take part in activities within the home and in the community. The activities were selected to match people's interests, age and health. A member of the staff team who lived in the local area had recently been tasked with finding more opportunities for people to take part in local community activities. The focus was on finding activities that were not specifically arranged for people with a learning disability. Support was available from the provider's social inclusion champion.

The service had a complaints procedure and complaints were recorded and addressed in line with this procedure. Two complaints had been received in the last 12 months and both had been thoroughly investigated and action taken to address the concerns raised. Relatives said they felt able to complain if they needed to and were confident any complaint would be dealt with appropriately. One relative said they had mentioned a concern to the manager and it had been addressed quickly and effectively. Most people living at the home would be unable to make a complaint verbally so staff monitored their behaviour for changes. If someone's behaviour changed, staff tried to find out if they were unhappy and address it.

Is the service well-led?

Our findings

Regular quality audits completed by the registered manager and the provider helped to monitor the quality of the service and identify the need for improvements. The quality audits had not, however, identified the service was not meeting the requirements of the Health and Social Care Act 2008 in relation to the management of medicines and record keeping. As a result, action had not been taken to improve these areas of practice. Incidents and accidents were reviewed every six months to check for patterns that needed addressing.

Until recently, there had been little effective monitoring of progress against the issues identified by the quality audits. For example, in December 2013 an audit had identified that supervision meetings with staff were not being undertaken frequently enough. Action was not taken until October 2014 and due to a lack of consistent oversight, this delay was not challenged. Similarly, a quality audit in July 2014 identified the service was not meeting the legal requirements of the Mental Capacity Act 2005 and this was still the case at the time of this inspection.

This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A new schedule of monthly quality visits based on the CQC five key questions was being introduced. The same external manager would complete each visit which would allow them to follow up actions from the previous visit. Prior to each visit, the staff team would be asked to discuss the key question to help the registered manager gather relevant evidence.

The registered manager shared with us some recently identified areas for improvement in the provider information return (PIR). These issues had come to light through quality audits and actions plans had been developed. Some progress had been made which was shared with us at the inspection. For example, the approach to fire safety checks had been changed to ensure checks were not missed when the fire marshal was on leave. Temperature checks were now being completed for the medicines cabinet to make sure medicines were being stored at a safe temperature.

The provider's expectations of how people should be treated by their staff were laid out in the company's values. These values included treating people with dignity and respect, giving them independence and control, respecting their individuality and acting in an inclusive way. The registered manager and staff understood the values set by the provider and we saw them being put into practice during our inspection. These values were shared with staff during corporate induction training and were reiterated at team meetings and during staff annual appraisal meetings.

Staff were committed to listening to people's views and the views of the people important to them in order to improve the service. Most people could not express their views using words so staff gathered feedback by monitoring people's mood and behaviour. The PIR stated people's relatives and professionals were asked for feedback using quality audits. Questionnaires had recently been sent out and a small number had been received back to date. The feedback was generally positive and action had been taken as a result of the comments received. For example, one family wanted more regular contact with their relative and this was being arranged. Concerns about messages and appointment not being shared with the necessary staff had been addressed by introducing a communication book and written handover records.

The registered manager had been in post for four months when we inspected. They told us they had benefitted from shadowing the previous manager before they left and had completed a local authority induction course for new managers. The PIR described the support the registered manager had from the provider. This included attending locality managers' meetings, receiving email updates on best practice and monitoring visits by the quality team. Staff described the registered manager as "firm but fair" and said they felt able to share concerns with him. Other staff said he was open to feedback and prepared to listen to staff. They all felt confident to raise concerns with him but none had needed to since he came to post. Staff were positive about the support they received to do their jobs. Staff understood their roles and responsibilities. This was discussed at induction and reiterated at meetings with their line manager.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Systems and process did not enable the registered person to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity and to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and those who may be at risk which arise from the carrying on of the regulated activity.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

The registered person was not acting in accordance with the 2005 Act when people were unable to give consent because they lacked capacity to do so.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Care was treatment was not being provided in a safe way for service users because;

- 1) Medicines were not being stored and recorded in a proper and safe way.
- 2) Risks to people's health and safety were not being mitigated through the maintenance of effective records about people's health needs.