Brett Lee Trust

The Brett Lee Trust

Inspection report

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Date of inspection visit:
13 October 2016

Date of publication:
17 November 2016

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

This inspection was announced and took place on the 13 October 2016. The Brett Lee Trust provides care and support to one person with a learning disability in their own home.

The service registered manager is a member of the provider's management team. 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.

Care was provided for one person within a relaxed home environment. The registered manager had an awareness of the Mental Capacity 2005 although we were not assured that the appropriate authorisations regarding the person's liberty were in place. We have made a referral to the appropriate authority.

The provider had received training in safeguarding people from abuse and was aware of what steps to take to protect the person. Risk assessments had been developed and risks managed so that the person was protected from undue risk. Medicines were stored safely and records kept of medicines received and administered.

The person was supported by a small, consistent team of care staff who were familiar with their needs. The person had access to health care services which meant their health care needs were met.

Meals were planned to support the person's health needs. Dietary advice had been sought when required.

Consideration had been given to maintaining relationships that were important to the person. They were supported with regular opportunities to participate in activities outside their home and sustain links in their local community.

Regular care reviews demonstrated that the provider worked in partnership with the local authority to provide good quality care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The likelihood of harm had been reduced because risks had been assessed and guidance provided to staff on how to manage risks and keep the person safe.

Medicines were stored safely and records kept of medicines received and administered.

Is the service effective?

Requires Improvement

The service was not acting within the guidelines of the Mental Capacity Act 2005.

The person had access to health care services which meant their health care needs were met.

Dietary advice had been sought when required. Meals were planned to support the person to maintain good health.

Is the service caring?

Good

The service was caring.

The person using the service looked well cared for and was relaxed within their environment.

Although not able to fully participate in the decision making process the person's wishes were respected.

Is the service responsive?

Good

The service was responsive.

Activities were provided according to the needs of the individual.

Care reviews were carried out on a regularly with input from the person's wider support network.

Is the service well-led?

Good

The service was well-led.

The provider was proactive in updating their skills and knowledge to enable them to understand the needs and rights of people with a learning disability.

Annual care reviews demonstrated that the provider worked in partnership with key organisations which included the local authority commissioning team. The quality and delivery of care was reviewed at these meetings.

The Brett Lee Trust

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 the 14 October 2016 and was announced. 48 hours' notice of the inspection was given because the service is small and provides care and support to one person living within a home environment; we needed to be sure that someone would be in.

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 improvements they plan to make. Before we visited the service we checked the information that we held about the service. No concerns had been raised.

During our inspection we observed support being provided to the person and interactions with care staff. We spoke with the provider who is also the registered manager and a member of care staff. We reviewed care records, assessed how the person was supported with their medication administration and viewed records relating to the management of the service.

Good

Is the service safe?

Our findings

The person who used the service had limited verbal communication and limited capacity to enable them to understand the question as to whether or not they felt safe living at the service. However, the interactions we observed between the person and the member of care staff were positive. It was evident from interactions observed and from verbal cues expressed that the person felt safe and comfortable within their environment.

Staff had received training in recognising and responding to abuse. The training records we viewed confirmed this. The provider demonstrated that they understood what abuse was and how they should report concerns if they had any. This showed that the risk of abuse was reduced.

Discussions with the registered manager and a review of care records showed us that risks had been assessed with detailed action plans produced which described how to support the person. These included environmental risks and those when undertaking various activities. We noted that some risk assessments in the care plan were written in 2012 and did not demonstrate they had been revised since then. The Registered Manager told us that the risk assessments were reviewed when the care plan was reviewed each year. They talked us through some of the risk assessments and demonstrated that they were still current and met the needs of the person.

Risk assessments described how to support the person when they presented with a particular medical condition. They gave clear instructions for staff to follow detailing what they should do to support the person to keep them and others safe. This included the administration of a particular medicine. Where an incident had occurred, we saw that the service had received advice from other professionals. This had helped the person manage their condition, which had resulted in less incidents happening.

The registered manager told us that one to one support was provided to the person at all times by a team of five full time care staff and the registered manager, Where the needs of the individual changed the registered manager told us that staffing numbers had been reviewed and adjusted, although this had not occurred recently. Staff holidays were managed by pro-active planning. Due to the small size of the team unexpected sickness could present a problem but to date this had been managed and the service had provided a financial incentive for staff to cover short notice shifts.

The service had recently recruited a new member of care staff and had followed safe recruitment practices checking that the person was suitable to work in this environment.

Medicines were stored safely and records kept of medicines received and administered. A medication profile had been developed which described details of any side effects to be observed. The provider had implemented a system of regular audit checks of medication administration records and regular checks of stock. Discussions with the provider and a review of care records showed us that regular medication reviews had been carried out with both a psychiatrist and community nursing staff with outcomes clearly recorded. We noted that one medicine which was prescribed to be given 'as required' (PRN) was being given daily. We

discussed this with the registered manager who was able to explain the reason it was currently being given daily. We are aware that since our inspection action has been taken to address this. Action taken by the provider reduced the risk of dispensing errors and ensured that the person received their medicines as prescribed which promoted their health and well-being.

Requires Improvement

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA. We found that although the registered manager had an awareness of the MCA the correct authorisations were not in place. This meant that the person could be being deprived of their liberty without proper legal authority. We have made a referral to the local authority that is responsible for making applications in this instance.

Staff received regular training and supervision of practice both formally and informally, for example when the registered manager accompanied the person on activities they also observed staff. Training for staff was tailored to the needs of the person receiving care.

The aims and objectives within the care plan were couched in terms of what the person chose, for example where they chose to live and that they chose, 'To have continual supervision and active support'. However, the care plan did not demonstrate how the person's mental capacity to make these decisions had been assessed. The person had the support of an advocate some years ago but contact with this person in their capacity as an advocate had ceased. This meant that we could not be sure that the decisions made had been always made in the person's best interest.

We observed staff giving the person choice in their daily life. For example asking if they wanted a cup of tea and if they wanted to watch the television. The person did not provide a verbal response but made their wishes clear with actions and gestures which were understood by the care worker.

The person's needs had been assessed and the care plan had been written in sufficient detail so that staff had the guidance they needed to support the person's needs appropriately. The provider and carer we spoke with were very knowledgeable about the person they supported. They were able to tell us about their needs, their likes, dislikes and preferences. They gave a good account of how they supported them. The information they gave us matched what was in the support plan which meant the person was being supported according to their assessed needs.

Meals were planned weekly and the menu was displayed in the home. The registered manager told us that the meals were planned to be healthy and support the person's wellbeing. We observed the person being supported to access regular drink. Care records reviewed showed us that nutritional needs had been assessed. We noted that dietary advice had been sought and actions taken to support a healthy diet.

The care plan contained detailed guidance on how best to support the person to maintain good health.

Regular access to health services had been organised and supported. For example, regular health checks took place with their GP, psychiatrist, specialist nurse, optician, dietician and dentist visits. The outcomes and actions required as a result of these visits had also been recorded. This demonstrated that the person's physical and mental health had been monitored and their healthcare needs were responded to.

Good

Is the service caring?

Our findings

We observed interactions between the person and their care worker. The person using the service looked well cared for and was relaxed within their environment. The care worker engaged positively and communicated with the person well using limited sounds, facial expressions and actions. We observed the person respond therefore showing the communication by the carer was appropriate and demonstrated an understanding.

The care records we reviewed had been written according to the assessed needs of the individual. Support plans contained information in relation to the individual's needs. It was evident from a review of records and discussions with the registered manager that important events such as family involvement and appointments with specialist health care professionals had been recognised and attended as required. The provider/registered manager had told us in the PIR that '[Person's] quality of life is very dependent upon their activities in the community and within [their]is own home and the interaction [they have]with [their] carers is a crucial element in this process.' During our observations within the service we saw that the person had a good relationship with their care worker.

We observed the person being involved in an immediate decision, such as what they wanted to drink. We spoke with the care worker about the activities the person participated in and how they chose whether or not to take part. They told us how on that day the person had been horse riding and how they had spoken with the person about where they were going that day. They had drawn a picture of a horse on a white board in the home. They told us that the person had not reacted until they had driven into the riding stables where the person had demonstrated body language which showed their pleasure. This included when they were riding the horse. The care worker told us that this was similar to when they took the person swimming, they demonstrated their enjoyment when they participated in the activity. The care worker told us that if they arrived at an activity and the person did not wish to take part they would offer an alternative such as having a coffee. This demonstrated that the person, although not able to participate in the full decision making process, was included and their responses respected and acted on to.

We saw that the person's privacy and dignity were promoted and respected by the staff. This, shutting doors when supporting the person with personal care to maintain their dignity. Care workers were discreet when they spoke to us about the person's health and well being and when carrying out personal care.

Good

Is the service responsive?

Our findings

Support had been provided to enable the person to take part in and follow their interests and hobbies. This included regular access to the local community. The person regularly took part in activities that interested them such as swimming, cycling and horse riding. The registered manager and care worker told us that if the person's ability to participate in these activities changed then the activities were reviewed. This demonstrated that the planning and provision of care was centred on the needs of the individual with support to access to activities that were important to them.

Care planning and discussion with the registered manager demonstrated that the service was aware of the person's changing health needs. For example the person may need to depend more on wheelchair support in the future because of changes in their mobility requirements. This had been addressed by the service which had also recognised the importance to the person's health of maintaining their mobility.

The provider demonstrated how care was provided to promote the person's individual needs and Preferences. A document had been produced entitled 'Brett's Lifestyle Planning'. This described how the person liked to live their daily life. It included information that they sometimes preferred solitude and that previous attempts to take the person on holiday had resulted in them becoming unsettled and keen to return home. The person was now taken on days out which they preferred to time away from their home. This demonstrated that the care the person received was personalised and responsive to their needs and wishes.

The provider told us that the person's care was reviewed regularly. Records we saw demonstrated consultation with healthcare professionals about the person's care and regular reviews of the care plan. The service was managed by a relative of the person who was therefore fully involved in the care provided. Other relatives who lived abroad were also consulted about the care of the person and were involved in the wider management team.

Good

Is the service well-led?

Our findings

The service's statement of purpose defined the principle of the service was to 'provide a safe and secure home for Brett Lee'. Everybody we spoke with as part of this inspection demonstrated their commitment to this statement.

There was a process in place for reporting accidents and incidents and we saw that these were followed. Daily notes evidenced a sharing of information between the provider and care staff. The provider pro-actively engaged with the day to day support of the person visiting or speaking with care staff on a daily basis and attending activities with them. The member of care staff we spoke with told us that the provider was approachable and engaged with them to support the person to lead a full an active lifestyle.

The provider told us that they kept up to date with changes relevant to the care they provided by pro-active networking and engagement with agencies such as Skills for Care. However, this method had not always proved completely successful as demonstrated by the lack of appropriate Court of Protection authority. We discussed this with the registered manager who recognised this as an issue. They said they would discuss and explore at the next team meeting ways of staying up to date with current good practice in caring for and understanding the rights of people with a learning disability.

Community care practitioners we spoke with from the local authority told us that the service had engaged with them in care reviews. The quality and delivery of care was reviewed at these meetings.