Turning Point

Turning Point - Follybridge House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 18,19 and 20 February 2019. Breaches of legal requirements were found. We issued two warning notices, which instructed the provider what areas and by when we expected improvement to made to the service.

We undertook this focused inspection to check they had made the necessary improvements and to confirm they now met legal requirements. The ratings from the previous comprehensive inspection for those Key Questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has not changed from requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection,by selecting the 'all reports' link for Turning Point-Follybridge House on our website at www.cqc.org.uk.

Enforcement
During this inspection we have identified a breach to Regulation 18: (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009 during this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.
People's experience of using this service and what we found
At the last inspection in February 2019 we found areas of concern relating to the safety and management of the service. We issued two warning notices. During this inspection we found improvements had been made to meet the requirements of the warning notices. However, some areas required further improvements. We found a breach of Regulation 18: (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009 at this inspection. This was because the provider failed to inform the Commission of an accident a person experienced. The Commission is unable to monitor how care is provided in services if we do not receive notifications.

During this inspection we also made two recommendations this was because we found although improvements had been made to the cleanliness of the service this could be enhanced further. The second recommendation was in relation to the speed and efficiency of responses when there were problems with equipment or the environment. For example, although Legionella tests had been completed in March 2019 the results weren't provided until July 2019. The provider failed to check on the results, which placed people at risk.

The service didn't apply the full range of principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence. The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons, due to the service's location there were limited opportunities for independence and community inclusion.

The service was situated on a busy main road, there was no pavement and no local amenities. This resulted in people not being supported to have maximum choice and control of their lives. Staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

There were deliberately no identifying signs, intercom, cameras, industrial bins or anything else outside to indicate it was a care home. Staff were also discouraged from wearing anything that suggested they were care staff when coming and going with people.

The service has a registered manager in place, who was not present during the inspection. An acting manager was covering in their absence. They had brought about improvements throughout the service with the support of the provider.

We found the environment had been decorated throughout, minus the laundry room, the spare bedroom and the office. The service felt homelier and more attractive than at the previous inspection.

Staff recruitment practices had improved which meant people were protected from the risk of being cared for by inappropriate personnel.

People's care plans had improved, and guidance was available to staff about how to care for people with diabetes. We discussed how these could be developed by including a description of hypoglycaemia (low blood sugar levels) and what action staff should take.

Medicines were managed and stored safely. Quality assurance audits had been completed and action plans recorded who was responsible and when the completion date was for any improvements.
Staff had received training in duty of candour this would enable them to comply with the regulation and to uphold an open and honest relationship with those they cared for.

The service worked in partnership with professionals and organisations to enhance the care they provided to people. For example, the local clinical commissioning group (CCG) supported the service and provided training and advice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was Requires Improvement report published (published 22 May 2019).

Following the previous inspection, we took enforcement action and issued two warning notices to the provider in relation to Regulation 12 (Safe Care and Treatment) and Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found some improvements had been made and the provider had met the

requirements of the warning notices but was in breach of a Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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.

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Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Turning Point - Follybridge House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by two inspectors.

Service and service type
Turning Point-Follybridge House is a 'care home'. People in care homes receive accommodation and nursing or personal 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. Follybridge accommodated five adults with learning disabilities at the time of our inspection. The service provided personal care up to six people who have a learning difficulty. At the time of our inspection five people lived at the service. Staff were present to care for people 24 hours a day and included a sleeping night staff and one who was awake all night.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider was not

asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.
We looked at previous inspection reports
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During the inspection-
We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We examined three people's care plans and spoke with three staff including the acting manager, a senior manager and a regional manager. We reviewed two people's medicine records and examined records related to the running of the service including incident and accident reports, audits and recruitment documents.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at accident reporting including medical notes and legionella and maintenance records. We corresponded with four professionals from the local authority.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to requires improvement.

Requires improvement: This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management

- At the last inspection in February 2019 we found several breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were placed at risk of scalding from two showers. We found hazardous cleaning materials and razor blades were not securely stored.
- We also found the house was not hygienic and several risks such as trip hazards and a lack of window restrictors in one bedroom made the service unsafe. There was also a lack of information for staff on how to support people with diabetes and how people were protected from the risk of Legionella.
- Systems were not in place to protect people from the risk of infection. When information was requested by the risk and assurance team regarding incidents or accidents this was not always provided. There were delays in rectifying broken or malfunctioning equipment or furniture in the service.
- During this inspection we found improvements had been made to some of the risks posed to people. For instance, improved medicines management. However, we found people were still at risk of harm.
- One person had a medical condition which placed them at risk of ingesting inedible items, like tissues. A risk assessment was in place to advise staff on how to minimise the risk of the person ingesting items. However, we found gloves and clinical waste bags were readily available to the person. Following the inspection, we were sent information which demonstrated these were now locked away.
- A legionella risk assessment was in place, however water tests in September 2018 identified legionella had been identified in one outlet. At the time of the inspection the senior management could not produce evidence this had been dealt with.
- Following the inspection, we received information that showed action had been taken to retest the water and maintenance work was undertaken to replace the boiler. The boiler had been replaced but this was not until nine months after the identification of legionella in the water supply. Following our inspection water samples had been taken to test for the presence of legionella.

We recommend the provider seek support and training, for the management team, about the identification, monitoring and action taken to improve the quality and safety of the service.

- The showers had been replaced. Hazardous cleaning materials and razor blades were stored securely. The hygiene of the service had improved which reduced the risk of infection.
- The paving slabs in the garden had been secured however there remained some trip hazards, these were

rectified following our inspection. Window restrictors had been put in place. Care plans related to diabetes had been improved.

Preventing and controlling infection

● During our last inspection in February 2019 we were concerned about the risk of transferring infections. This was due to a bin that was broken, although this had been identified in the infection control audit carried out on 2 January 2019 no action had been taken to address the problem. The inside of the cooker was covered in food spillages and was unhygienic.

● Food was not stored safely. The kitchen was in a state of disrepair. An infection control audit was not accurately completed and in accordance with our findings. There was no separate cleaning audit.

● Since our last inspection the service had been re-decorated. We found the environment to be clean and welcoming. However, some areas still required improvement.

● We found areas within the laundry room, open to widespread growth of infections. The floor coverings in the office and laundry were damaged and were unable to be cleaned effectively.

● We found cobwebs and spiders present in people's rooms. A cleaning schedule was in place however, we found floor mops were stored incorrectly and had the potential to propagate infection.

We recommend the service seek advice from a reputable source regarding the cleanliness and hygiene of the service.

Staffing and recruitment

● During our last inspection in February 2019 we made a recommendation about the review of staffing levels in the service. During this inspection we found there were sufficient numbers of staff to meet the needs of people, this was because there was an acting manager who spent more time at the service.

● People were supported by staff who had been recruited safely. The provider ensured all the required pre-employment checks were completed. These included an employment history, references and Disclosure and Barring Service checks (DBS). A DBS is a criminal record check. The recruitment process for staff had improved because gaps in recruitment histories were now explored to ensure staff were safe to work with people.

● We observed staff provided supervision with meal times as described in people's care plans. For Instance, one person's care plan advised they should be supervised and reminded to eat slowly. We observed this to be the case.

Using medicines safely

● During our last inspection in February 2019 we had concerns about the security of the medicines. We also found discrepancies between records and the actual stock of medicines and the lack of frequent medicines audits.

● During this inspection we found improvements had been made and medicines were stored securely. Stock checks and audits were carried out regularly. We found the stock of medicine matched that described in records.

Learning lessons when things go wrong

● At the last inspection we had concerns the management of the service were not updating records related to accidents and incidents when requested to do so. The registered manager reported defects in equipment but failed to chase up remedial action in a timely way.

During this inspection we found the provider had systems in place to record and monitor incidents and accidents.

● We noted incidents and accidents were allocated to a manager within the organisation to investigate. The

provider's risk and assurance team checked the reporting system and produced a quarterly analysis to identify any trends or learning.

- The provider had a system in place to cascade learning from any of their locations to the service.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- At the last inspection in February 2019 we found a lack of management presence in the service and a lack of quality assurance and governance had led to a breach of Regulation 17(Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- During this inspection we found the management presence had increased and was effective, the quality of the audits had improved. This meant there was an overview of the service and how things could be enhanced.
- Action plans had been drawn up by the acting manager with records of whom and when the actions would be completed.
- However, we were concerned that senior staff did not understand the regulatory requirements they were expected to adhere to. This was because a person had an accident and received medical treatment. The provider has a legal duty to inform the Commission when such events occur and where an injury to a person which, if left untreated, would lead to prolonged pain or changes to the structure of the body of the person or even death.
- The registered manager and the provider had failed to recognise their responsibility to notify the Commission of this incident.

This was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- During our last inspection in February 2019 we had the standard of care was not always safe or person centred.
- During this inspection we found improvements had been made. We could see how the acting manager had endeavoured to establish a positive culture as care plans had improved and they understood the needs of people living in the service.
- The service was a brighter homelier environment for people. Improvements had been made, however acknowledgement was given by senior management further improvements were needed. For example, the response times of action when things go wrong needed to accelerate.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● At the previous inspection in February 2019 we made a recommendation about the duty of candour. Records showed staff had received a training session as part of the staff meeting on what the regulation meant and how it applied to their role. At the time of this inspection there were no records to show this had needed to be implemented.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People were encouraged to participate in community activities for example eating out. Not everyone could cope with crowds or noise, countryside walks were available if they wished to participate. Some people attended a day centre which helped engage them with people outside of the service. People were supported to maintain relationships with family members and those who were important to them.

Continuous learning and improving care

● The provider had systems in place to learn from when care was not delivered as planned. The provider had an internal online system which staff had access to, messages were placed on the online system about learning.

● The provider cascaded information about any national safety alerts. The provider's risk and assurance team sent information to staff through their internal communication methods.

●The service worked with local authorities and healthcare professionals to ensure people received the right support. For instance, people had been referred to an occupational therapist when they were at risk of falling.

Working in partnership with others

● Since the last inspection in February 2019 we are aware the service has been working closely with the local clinical commissioning group (CCG). This organisation funds the placement of the people living in the service. Records showed the CCG had been assisting the service to improve by providing specialist training and advice. Where people required the assistance of other professionals such a health professional this was organised, and people received the appropriate support needed.

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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to inform the commission of incidents including (a) any injury to a service user which, in the reasonable opinion of a health care professional, requires treatment by that, or another, health care professional to prevent— (i) the death of the service user, or (ii) an injury to the service user which, if left untreated, would lead to one or more of the outcomes mentioned in sub-paragraph (a); Regulation 18: (2) (b) (i) (ii) Notification of other incidents