Mrs L Whitehouse

St Brigas Residential Home For Adults with Learning Disabilities

Inspection report

St Brigas
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Clevedon
Somerset
BS21 7SA
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Website: www.stbrigas.co.uk

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

We carried out this unannounced inspection on the 23 and 27 July 2015. At our last inspection in June 2013 no concerns were identified.

St Brigas provides accommodation for up to 17 people who have a learning disability and who require support and personal care. At the time of the inspection there were 15 people living at the home. St Brigas has 17

Summary of findings

bedrooms, most have en-suites. There is a communal dining room, conservatory, art room, music/activities room, quite room, kitchen for people to use and make their own drinks, two offices, outside front and rear gardens and an outside wood work room. On the third floor is another office, staff sleeping room and staff bathroom.

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 ae 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 was present on the second day of the inspection.

The registered manager confirmed staff had appropriate checks and where staff had worked at the service for a number of years they monitored their suitability through supervisions. People were not being protected from the risk of infections due to staff not using gloves, aprons and red disposable laundry bags. Environmental and individual risk assessments did not contain guidelines to show how risks were being managed.

People who were unable to consent to care and treatment did not have mental capacity assessments completed or best interest decisions in place that confirmed who had been involved. Staff demonstrated how they give people choice around their daily support. The service was identifying when people might be at risk of having restrictions placed on their liberty and applications were in place to confirm this.

Staffing levels at the home were good and staff were skilled in communications with people, especially if people were unable to communicate verbally. Staff felt happy and well supported by the management team. Training was provided to staff so they could understand and support people with their individual care needs. There was enough staff to ensure people had their one to one support. People received their medicines safely by staff who had received training. Medicines were accurately being recorded and adequately stored.

People were supported by staff who demonstrated a kind and caring approach. People received consistent support from staff who knew them well. People and relatives felt safe and were happy with the care. People had support to access activities and their local community. People received a service that was based and their personal needs and wishes. Changes in people's needs were quickly identified and contact was made with their health care professional.

There was a lack of robust audits that identified areas of concern found during the inspection. There was a complaints policy with an easy read version available to people and relatives. Annual surveys were sent to people, relatives and professionals about the quality of the service.

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

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?

People were not always safe. Records did not give staff guidelines to follow where risks were identified although all staff we spoke with knew people well. There was no overall analysis of incidents and accidents and actions taken.

Recruitment procedures were undertaken and the registered manager confirmed staff were reviewed regarding their suitability and had appropriate checks completed.

People were at risk of infections due to poor use of personal protective equipment whilst staff provided care and support.

Requires improvement

Is the service effective?

The service was not effective. People did not have appropriate assessments and best interest paperwork in place when they were unable to consent to their care and treatment. This meant their rights were not always protected.

People were well supported by health and social care professionals. This made sure they received appropriate care and treatment.

Staff had good knowledge of each person and how to meet their needs.

Requires improvement

Is the service caring?

The service was caring. Staff worked in a kind and caring manner with people and demonstrated understanding when delivering care and support.

People received care and support from staff who demonstrated respect for dignity and understood people's needs well.

People were supported with hobbies and interests that were important to them along with support to maintain relationships.

Good

Is the service responsive?

The service was responsive. People received care and support that was responsive to their changing needs.

People chose a lifestyle which suited them and were supported to access the community and personal interests.

People and those close to them were involved in planning and reviewing their care.

Good

Is the service well-led?

The service was not always well-led.

The service people received was not always monitored effectively to ensure it was appropriate, safe and of good quality. Areas for improvement were not always identified.

Requires improvement

Summary of findings

People were part of the local community and were supported by staff when required to facilitate this access.

People, relatives and professionals were having their views sought so that improvements could be made for people's care and experience.

Staff felt happy and well supported by the management team at the home.

St Brigas Residential Home For Adults with Learning Disabilities

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 checked 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 was an unannounced inspection that took place over two days on the 23 and 27 July 2015. It was carried out by one inspector.

We spoke with three people living at St Brigas, one relative, two care staff, the handyman, two cleaners, the deputy, the finance administrator and the registered manager. We also spoke with one visiting health care professionals to gain their views of the service.

We looked at three people's care records and documentation in relation to the management of the

home. This included three staff files including supervision, training and recruitment records, quality auditing processes and policies and procedures. We looked around the premises, observed care practices and the administration of medicines.

Before our inspection we reviewed all information we held about the home, including intelligence we had received about the service and notifications. Notifications are information about specific important events the service is legally required to send to us. We also reviewed the Provider Information Return (PIR) and previous inspection reports. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make.

Requires improvement

Is the service safe?

Our findings

Although people and relatives told us they felt safe, we found recruitment procedures and systems were not always ensuring staff had adequate checks in place before their employment or whilst employed. For example, we found one new member of staff had started employment without having a Disclosure and Barring Service check (DBS) completed. We also found nine staff who had worked for the service for over 15 years had no updated or recent checks completed to ensure they were still fit to work with vulnerable adults. We fed this back to the registered manager who sent us confirmation after the inspection that all staff have a current DBS and staff have supervisions which check their character is still suitable.

The service was not ensuring accurate records were maintained for incidents and accidents so trends could be reviewed and analysed. For example, we found in three people's individual daily records six occasions where the person had either slipped, banged their head, or had unexplained bruising. We found no incident and accident forms relating to these injuries and no overall analysis. The registered manager confirmed they had no overall system in place that confirmed the amount of incidents or that identified trends and actions taken. This meant people could be at risk due to lack of records that identify trends and actions taken relating to their care and treatment.

The service did not always ensure risks to people and the environmental were identified and recorded. For example, where one person was at risk of falling and required a support brace to be applied every day. The care plan identified the person wore a support brace but there was no guidelines that identifying the risk and how this was being managed. An environmental risk assessment also failed to identify risks where one person had accessed the medication cabinet and taken medication not prescribed for them.

We spoke to staff and the registered manager about the risks to people regarding the environment and accessing the medication cabinet. They all confirmed how they ensured people were safe and what they did to ensure people were safe. They told us "Today I supported [name] with their brace" and "We make sure [name] can always see the minibus, it helps with their anxiety" and "At night we now lock the main door to the dining around and the conservatory doors, this is since the medication incident". This meant people were supported by staff who knew how to keep them safe but records did not always include guidelines for staff to follow.

This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of infections due to poor use of personal protective equipment and inappropriate infection control measures. For example, we found there were no disposable red bags for the laundering of soiled and contaminated laundry and staff were not wearing aprons whilst handling dirty laundry. Staff confirmed the lack of red disposable laundry bags and disposable aprons. They told us "I always put my gloves on to handle the laundry but we don't use aprons it's in discussion. Red disposable bags unsure where these are" and "Don't tend to wear aprons, I don't think we have any". Laundry baskets had recently been replaced but there was no confirmation which bin was being used for what type of laundry.

This was a breach of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Action had been taken by the second day of our inspection and these bins had been labelled to confirm what type of laundry they should be used for. Areas of the home were clean and tidy and there was a schedule in place to complete daily and weekly cleaning tasks. The registered manager confirmed they would action ordering aprons and red disposable bags.

People received their medicines safely. Medicines were administered by trained staff. Medicines were locked and stored securely. Medicines administration records were accurate and complete, photographs aided identification.

People, staff and relatives told us that they felt safe living at St Brigas. Two people told us "Safe I do" and "I like them and here". Staff had been trained in safeguarding adults the deputy had undertaken enhanced safeguarding training. Staff were able to confirm what they would do if they thought abuse was occurring. They told us "I have no reason to be concerned but if I did have any worries I would go to the registered manager or deputy" and "I would report it through to the local teams and read the policy that we have" and "If I had concerns about how someone was being treated by other people I would report it. I feel everyone is safe". One parent told us "Yes I feel it is safe and a safe environment".

Requires improvement

Is the service safe?

People had detailed support plans in place that identified triggers and what support staff should provide if there was a problem. Staff knew people well and were able to confirm the details of people's support plans. For example one member of staff confirmed some triggers, "[name] doesn't like door shut behind then it will upset them", and for another person "We have to be aware of space and often will get directed by the person if we are too close". Both behaviour support plans confirmed details relating to those triggers.

People had personal emergency plans, for example in the case of a fire. Information included next of kin details and important information relating to that person. The home had a fire bag to grab in an emergency. Guidelines confirmed action staff should take if they required emergency support with a nearby home. Two personal emergency plans did not contain personal items of clothing important to two people. We discussed this with the deputy. They confirmed all staff knew the importance of the clothing items should an emergency arise. The deputy confirmed they would update the personal emergency plans to include this information. This meant people had emergency arrangements and contingency plans in case of an emergency.

People were supported by staffing numbers which ensured their safety. There was a consistent staff team which meant people and staff got to know people well. The registered manager confirmed staffing numbers varied depending on activities and people's needs. Throughout the inspection people were supported by staff one to one and within group activities. Staff told us "[Name] is timetabled to go out with staff, we go for regular walks we have one planned this afternoon". One parent told us "[Name] has the support they need". Rotas were planned in advance to ensure adequate staffing was provided. The registered manager and deputy both confirmed they provide additional support as required. On the second day of our inspection the deputy provided additional care support to one person who had become unwell.

There was a system to ensure checks had been completed on gas, electric, portable appliance tests and water. Certificates confirmed these were in date. This ensured areas of the homes essential supplies were checked and safe.

Requires improvement

Is the service effective?

Our findings

The service was not always effective. Where people were unable to make decisions the principles of the Mental Capacity Act 2005 were not always being followed. This related to daily decisions relating to people's care and treatment. For example, one person had food cut up due to risks of choking, medication was administered covertly and support and medication was provided each month for their health needs. Their care plan confirmed this information but we found no mental capacity assessment or best interest decisions relating to their care and welfare and who had been involved in this decision. This meant the service was not ensuring their rights were protected under the Mental Capacity Act 2005.

This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have capacity to make certain decisions and there is no other way to look after the person safely. The main gates to St Brigas were continually locked preventing people from easily leaving the premises. The deputy manager confirmed the reason behind these gates being locked. Two DoLS authorisations had been granted relating to the locking of the main gate. People who were not subject to the DoLs had guidelines in place identifying this risk but confirmed the DoLS did not relate to them. Staff we spoke with confirmed how they supported people who were not subject to the DoLS. During the two days of the inspection people who did not need support were able to come and go as they wished. This meant the service was ensuring applications were being made if they considered the person was being deprived of their liberty.

People had access to health care professionals to meet their specific needs. People saw their general practitioner, dentist and optician when they needed to. One relative felt staff knew people well and were quick to seek medical attention should people need it. They told us "Staff are very quick and on to things if the residents aren't right they are very quick here to react. [Name] wouldn't say if unwell so relies on staff to know them well". One visiting health care professional told us "They are very good at calling us appropriately, staff know people and when they are unwell". This meant people were supported by staff who knew them well.

Staff felt well supported and happy. They told us "I feel well supported and I feel my opinion matters" and "I can talk to [registered manager] if I need to" and "Yes I feel I get enough, if I need to I would always go to [registered manager] if needed" and "It is all good, always approachable and able to talk with them". The deputy manager confirmed they undertook observed practice with staff and were always talking with staff about things that went well or could be done better. They had started to implement a record of these observed practices and felt it was working really well.

Staff told us they had a variety of training opportunities and all felt well trained. Staff told us "Training is good the last one was safeguarding" and "Staff attend relevant training to people we support" examples given were diabetics and Angelman syndrome. The staff training records confirmed staff received training in safeguarding adults, moving and handling, Mental Capacity Act and DoLS. Training that was required had been booked and we saw forthcoming dates for all staff to attend first aid training. This meant people were supported by staff who had undertaken training to meet their needs.

Not all people in the home were able to communicate verbally. Those who were unable used different methods such as noises, pointing, directing or physically leading staff to show them what they wanted. Staff knew people well and were able to interpret their body language or non-verbal communication. Care plans contained information that confirmed how people communicated and what methods they used. For example, one person's care plan confirmed their method of communication was non-verbal. It confirmed the person had recently started saying no and that they might direct staff by putting their hand on their shoulder. This method was used throughout our inspection. Their care plan also confirmed what might show they were unhappy and needed more space. Staff we spoke with knew this person well, they were all able to confirm what methods of communication this person used and what might show they were unhappy.

People had a varied and balanced diet. There was a four weekly menu based on people's known choice. The chef confirmed menus are were chosen by people, they told us

Requires improvement

Is the service effective?

"people choose the menu's, they get a choice, staff would tell me if it's not worth doing". We saw breakfast and lunch being served throughout the two days of the inspection. People sat in the dining or conservatory area choosing where they wanted to sit. One person had breakfast in their room on morning. People had a variety of options available for example, fruit, toast and cereal was available for breakfast along with various sandwiches, crisps and or fruit for lunch. Staff were present during meals but people ate without staff support, staff only offered at times encouragement or a little prompting. Care plans reflected people's known choice about their likes and dislikes relating to their diet.

People had bedrooms that were personal to them. We spoke with one person about their bedroom decoration. They told us they had recently chosen the colour themselves. Bedrooms contained people's personal belongings such as pictures, music, musical instruments and photographs.

Good

Is the service caring?

Our findings

People and staff were happy at St Brigas. Not all people were able to comment, but two people told us, "I like it here" and "It is nice here". One parent told us "Staff are excellent, they ensure [name] 100% needs are met". They felt staff and the environment was warm and greeting. They told us "It is always warm and people are engaging with each other, there isn't an atmosphere".

We observed kind and caring interactions between people and staff. People interacted with each other as they went about the home. The atmosphere in the home was calm and staff spent time talking to people with compassion and kindness. Staff spoke with people in a polite and respectful manner and they took time to await responses from people. For example, some people liked their own personal space, staff were good at ensuring people and others were aware of how one person liked their space and for this to be respected they informed visitors of this on their arrival.

People had their rooms decorated to their personal wishes and interests. We were shown people's rooms, the member of staff explained how people were supported to make decisions around the colour, furniture and posters and memorabilia. For example they told us "[name] loves pink, they picked the colour themselves which reflects their love for pink" and "[name] loves golf" and "Loves horses" and "Music is important to [name]". People's rooms reflected what was important to them.

Care staff were respectful of people's privacy and maintained their dignity. They told us how they give people privacy whilst they undertook personal care routines. Staff knocked and waited before they entered people's rooms. One staff member supported one person discretely with their personal care routine. They allowed the person to guide them and direct them to achieve the support needed. Their care plan confirmed this method of directing staff as this was how the person expressed what they wanted. Not all people were able to express their views. One parent that we spoke with told us how involved they are in the persons care planning and how staff know them very well. They told us, "[Name] is respected and happy, I would know if [name] isn't" and "[Name] keyworker rings me up if there are any changes I feel very involved". This meant where people were unable to express views in their care and treatment parents had their views sought.

Care plans recorded people's interests and hobbies. Timetables had planned daily activities that reflected people's interests. One person confirmed how they enjoyed going out to visit friends. They told us "I have been out this morning to visit my friend". One parent told us, "[Name] enjoys going for walks and the café". Staff we spoke with told us "[Name] enjoys going for walks, we are going for one this afternoon". Their timetable confirmed those interests. This meant people were supported to access activities that were important to them.

People were supported to maintain relationships with the people who were important to them, such as their parents and friends. One person we spoke with told us, I have been visiting my friend today". Staff talked to this person about their visit and if they had enjoyed it. Another person confirmed their family visited them most weeks, they told us "[name] comes to see me every other Thursday, I enjoy it". Parents and relatives were encouraged to visit. One parent said, "I visit most weeks and I phone at other times. Staff are always very approachable and I will always get a good update from what [Name] has been up to".

One healthcare professional told us that when they visited St Brigas they observed staff respond to people appropriately and that the atmosphere of the home was positive. They felt people had support by staff who were knowledgeable about their individual needs and complexities.

Good

Is the service responsive?

Our findings

People were well supported and had one to one support from staff at times. People were able to plan their day with staff. Some activities were pre-planned and others were decided on the day. On both days of the inspection people were busy coming and going at various times. People were able to do the things they wished to do.

During our inspection some people went to their local day centre and out for a morning at the local garden centre. There was a relaxation session that was held before lunch, three people attended this chosen activity. Other people spent time relaxing at the home, in their room, or walking around the garden and listening to music. Weekly timetables showed people went to hydro therapy, the cinema, music and dance therapy and accessed their local community. Staff had access to a mini bus to take people out and this was used on both days of the inspection. The home had a room where people listened to music and could access computers and the internet. There was also an art room where people drew and made pictures, people could use these when they wished.

People participated in the planning and review of their care as much as they were able to. Others close to them, such as their parents and other professionals involved in their care were also consulted. One member of staff told us how they liaise with one person's professional to ensure they are involved in any decision. This was particularly important for this person as they had no immediate family and their care needs were complex. One parent and professional we spoke with told us how good the service was at responding to people's changing needs, they told us "They are quick to react if the residents aren't right" and "Staff know patients very well and know when they are unwell".

Care plans included people's interests, like and dislikes, communication and support needs. For example where people had particular routines they liked to follow these were recorded. Staff knew people well and were able to confirm how they individually support people. They told us "We know [name] has a phobia of water and not to shut the door behind them. We also have to be careful of dogs". Another member of staff told us "[name] doesn't like people in their own space; they will direct you normally by your shoulder".

There was a complaints policy and procedure in place, there had been one complaint made in the last four years. There was an easy read complaint policy in place. Some people would rely on staff or relatives to make a complaint. One parent we spoke with had never felt unhappy but felt happy to make a complaint should they need to, they told us "I have not had a reason to complain, if I did I would speak to staff, and solve it straight way". The complaints policy was assessable in the entrance to the building and we saw copies of the easy read version in people's room.

People were supported by the service when their needs changed. For example two people required monitoring overnight due to their epilepsy. The provider had purchased two alarms that fitted to the persons' mattress, if there was a change to their sleeping and their required assistance and alarm would sound informing the carer they required assistance. This meant people received care that was personalised to their care needs.

Requires improvement

Is the service well-led?

Our findings

The service was not always well-led. The provider had some quality assurance systems in place to monitor the quality and safety of the service but some areas had not identified where improvements were required. For example, we found recruitment procedures and systems were not always ensuring staff had adequate checks in place before their employment or whilst employed. Staff were not using personal protective equipment whilst administering medicines or handling soiled and contaminated laundry. Risk assessments, mental capacity assessments and best interest decisions along with incidents and accidents were not always accurate or in place.

This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A registered manager was responsible for the service; they were supported by a deputy manager. Both the registered manager and deputy walked about the service engaging and supporting people. Staff told us how much they enjoyed working at the home and they felt that the managers and deputy were very supportive. They told us "If I need to I would always go to [registered manager] and [deputy manager], I enjoy it here" and "They are always approachable, I am able to talk to managers" and "I have worked here for 16 years, [name & name] always happy to support".

People were part of their local community. They were encouraged and supported to use community facilities, such as local shops, cafes, pubs, cinemas and garden centres. People went into town, caught up with friends and out for walks in the local area during our inspection. One person told us how they had visited their friend one morning and one member of staff told us how they would support people to go for a walk during the afternoon.

Annual surveys were circulated to people, relatives and those professionals involved in people's care. The outcome from the latest survey in June 2015 was positive, with most people being either happy or very happy overall. Two areas people felt needed improvement were the laundry and décor of the home. The registered manager confirmed they had undertaken a health and safety walk around of the building. It identified areas for improvement including the décor of the home. They told us the décor was being prioritised and "it is on a need basis". There was a comprehensive development plan in place and we saw some areas had already been addressed. However during the inspection we found some areas had not been identified, for example the art room and music room walls where the plaster had blown and was peeling. The registered manager confirmed this was an on going problem as the building was old and was letting water in through outside brick work. They confirmed the maintenance man was due to fix it.

On going improvements were being made to the facilities and furnishings of the home. A new carpet had been purchased for one person and there was a new carpet in the dining and conservatory area. A new TV had been purchased following the previous one being damaged. Two people had been supported with a personalised chair where they could relax and rock themselves. One communal bathroom had been identified to be made into a wet room. The registered manager confirmed this work was due to start soon.

Staff had access to regular staff meetings. These provided an opportunity to discuss openly any concerns or topics to address. Opportunities were provided to suggest learning and getting care right. For example, minutes confirmed a change to one person's support need and a request to keep receipts so that people's expenses could be monitored and logged. All staff we spoke with felt happy with the support they received from the management team.

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	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider was not ensuring where people lacked capacity that assessments and best interest decisions were in place as required by The Mental Capacity Act 2005 Regulation 11 (1) (2) (3) (4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider had not protected against the risk of infections due to the lack of adequate personal protective equipment and ensuring soiled laundry is handled and stored as required. Regulation 15 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use the service were not protected due to lack of complete records relating to incidents and accidents and risk assessments. The provider had not established systems to monitor the quality and effectiveness of the service. Regulation 17 (1) (2)(a)(b)(c)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.