IBC Quality Solutions Limited

Tarry Hill

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection visit took place on 10 October 2018 and was unannounced. It was completed by one inspector, an assistant inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Tarry Hill is set on a large communal site which includes supported living units. This home was registered before the introduction of Registering the Right Support; however, the service aims to adhere to the values set out as best practice. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. The home 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.

Tarry Hill is five small homes set on one communal site. Each home was independent with their own communal spaces, kitchen and bedrooms for each person. There was a registered manager at this location. 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.'

When people had been identified as being at risk, assessments had not always been completed to provide the details and guidance required. People were not always protected from the risk of infection in relation to cleaning schedules and the use of personal protective equipment. We have made a recommendation in relation to the risk assessments and support people from other associated risks. Medicines were not always managed safely when people required as required medicine or medicine for a specific condition.

The staff were provided to meet the commissioned needs of individuals. However, when new agency staff had been employed to support people they were not given an induction or clear direction for their role in supporting people.

The provider had completed audits in relation to the ongoing improvement however these were not always effective. Notifications had not always been completed in relation to events. People had been encouraged to voice their feedback, however there was no formal process and areas identified in the past had not been addressed.

Staff had received skills to support people's individual needs. Training was ongoing and new initiatives were being developed. People's nutritional needs had been met and specific diets observed and supported.

Health care professionals had been regularly consulted to support people to achieve better outcomes for their health care and wellbeing. People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

The provider worked with a range of internal and external healthcare professionals. They also worked in partnership with a range of organisations.

Staff had established positive relationships with people and knew people well. Staff showed kindness and compassion when delivering care. People's dignity had been respected.

Care plans for people reflected a lot of detail and included people's preferences. These included their communications methods and any cultural requirements. People enjoyed activities of their choice.

Complaints had been responded to. People were protected from harm and lessons had been learnt from events to drive improvements in this area. Staff and professionals were positive about the management changes within the home. Partnerships had been developed with a range of professionals to support people's health had wellbeing.

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

Risks had not always been assessed and the details and guidance provided to reduce the risk was not recorded. Medicines were not always managed safety and people were not always protected from the risk of infection.

There was sufficient staff and these had been recruited safety, however not all the agency staff had received an induction and support when they started.

People were protected from harm and lessons had been learnt from events to drive improvements.

Is the service effective?

Good

The service was effective

Staff had received skills to support people's individual needs. Training was ongoing and new initiatives were being developed.

People's rights were protected and staff supported people to make decisions. The principles of the Deprivation of Liberty Safeguards were understood and applied correctly and people were supported in the least restrictive way possible.

People's healthcare had been developed to provide them with a better quality of life. The provider worked with a range of internal and external healthcare professionals.

People were supported to have their dietary needs met. They were encouraged to make choices and had an opportunity to develop independence in this area.

The environment had been considered for people's needs and there was an opportunity for people to personalise their own space.

Is the service caring?

Good

The service was caring

Staff had established positive and compassionate relationships with people.
Advocates were available to support people's decisions.

People were encouraged to make choices about their day and routines were followed to provide consistency.

People retained their dignity with the care of the staff. Privacy was respected and observed.

Is the service responsive?

Good

The service was responsive

People had detailed care plans which provide staff with the information needed to ensure the care provided met their individual needs.Plans included communications needs and any cultural requirements.

People were encouraged to enjoy activities and opportunities to go out.
Complaints had been responded to.

Is the service well-led?

Requires Improvement

The service was not always well led

Measures to reflect the quality and ongoing improvement had not always been effective. Notifications had not always been completed in relation to events.

People had been encouraged to voice their feedback, however there was no formal process and areas identified for improvement in the past, had not been addressed.

Staff and professionals were positive about the management changes within the home. Partnerships had been developed with a range of professionals to support people's health had wellbeing.

Tarry Hill

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.

The provider had completed a Provider Information Return as part of the Provider Information Collection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also checked the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service. We reviewed the quality monitoring report that the local authority had sent to us. All this information was used to formulate our inspection plan.

Not everyone in the home could tell us about their experience of their life in the home, so we observed how the staff interacted with people in communal areas. However, we spoke with eight people with varying levels of comprehension. We also spoke with three members of care staff, three senior staff, the deputy manager and the registered manager. After the inspection we contacted two health care professionals and two social care professionals. In addition, we contacted two family relatives by telephone and or email.

We looked at the care records for three people. We checked that the care they received matched the information in their records. We also looked at a range of information to consider how the home ensured the quality of the service was continuously reviewed, these included audits relating to accidents and incidents, infection control audits, complaints, compliments and surveys to reflect feedback.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed safety. For example, some people required medicine to be provided in an emergency. For each person there was a protocol and before staff could administer the medicine they were required to receive specific training. Some staff had not received the training and had taken the person off site for activities. This meant in the case of an emergency, the person may not have access to the medicine they required to support their condition. We discussed this medicine with a health care professional who told us the person had not required the medicine for some time. However, the recording for this medicine had not always been consistent to show the number of times it had been administered in any given period. A health care professional said, "Communication has been an issue in the past; this is improving. They have now got the charts to complete." We spoke with the registered manager who told us they would review this practice directly and provided us with assurances after the inspection this practice had been addressed.

Medicines which were provided on an as required basis did not always have a protocol to provide staff with the correct guidance. We saw this had been identified during the provider's pharmacy inspection and measures were being taken to rectify this area. The deputy had sourced some easy read resources so that some people could be supported to communicate if they felt unwell. They had also obtained a pain chart guide which could be used for people unable to verbalise how they felt. Both these items were in the process of being implemented. Other medicines were administered in line with guidance. This included the correct storage, stock control and the completion of the medicine administration records.

Risk assessments had not always been completed for some areas of identified risk. Some areas within the care plan had detailed the needs of the person and the action staff should take, however a specific risk assessment had not always been completed. In addition, some risk areas had not been reviewed following a change in the persons care needs. This included the review of the personal evacuation plans. These are used to reflect the needs of the person should there be an emergency for example a fire. However, we reviewed other risk assessments which were detailed and provided clear guidance to the risk identified and the support staff should provide. For example, when people were supported when they went out or when they travelled in vehicles.

One person was at risk of choking. This person had been assessed by the speech and language therapist (SALT), however we were unable to locate the SALT assessments. Some staff we spoke with were unclear as to when the thickener should be used and to what consistency. This placed the person at risk. We asked the registered manager to review the assessment with SALT and to ensure clear guidance was available to all staff and within the persons care plan.

Other people's risks in relation to their dietary needs had been completed and we observed these were followed by staff. This is detailed in the effective section of the report.

People were not always protected from the risks associated with the control of infection. We observed staff did not always use personal protective equipment (PPE) when preparing meals and an agency staff member

told us, "I have not been shown were the PPE is." We saw the staff in each home was responsible for the cleaning. There were no cleaning schedules in place and we saw in one of the houses, the kitchen had not been maintained to a good level of hygiene. Some cleaning products were observed to be accessible and not locked away which could present a risk for people.

We recommend that the service reviews their risk assessments and other associated risk for people, based on current best practice.

The registered manager had used agency staff to support some areas of the care required at Tarry Hill. When new agency staff attended they were not provided with a basic induction. An agency staff member said, "I was not given an introduction, I even had to ask people's names. I am not sure what I need to do with each person in supporting them." We saw some agency staff had worked at the home for several years and these staff provided consistency and had become part of the staff team. The provider had an ongoing programme of recruitment as they wished to reduce their reliance on the use of agency staff.

We saw there was a lot of staff who had worked for the provider for many years. Staff worked with people to develop their relationships and understood individual's needs. One relative said, "You have to get the right staff and I know these staff care." Staff were very knowledgeable about people and this helped them to manage different situations. Many of the people required one to one or two to one staff support as part of their agreed care with the local commissioners. We saw the staffing was in line with these requirements. Additional staff were placed on shift to support appointments and other social events.

The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them. For example, before staff were employed, criminal record checks were undertaken through the Disclosure and Barring Service. These checks are used to assist employers to make safer recruitment decisions.

Some people expressed themselves in a way which could harm themselves or others. We saw for these people there was detailed plans which reflected possible triggers and guidance and ways to distract them. Staff had received training in restraint and when this had been used, this had been recorded. One relative said, "Restraint is hardly used, but when required, we have been informed. Staff knew [Name] well so it rarely reaches that stage." The registered manager and another senior had been trained to train other staff in restraint. One staff member told us, "Now they cover all aspects including completing the forms, the debrief and the wind down. It's nice to see this as its important to keep ourselves and people safe." We reviewed the recording of the incidents and these supported the planned approach for the person and reflected limited restraint which was used to maintain the person's own safety.

All the staff we spoke with had a detailed knowledge of how to protect people from the risk of abuse. One staff member told us, "We have raised safeguards here if necessary. The management are very active and would action any concerns. If not, I would go to the local authority directly." We saw that when safeguards had been raised these were investigated and actions put in place. Although there was information available for people, this item had not been included in the house meetings. The registered manager told us they would review this and include in future meetings.

Safeguards and other incidents had been used to drive improvements. For example, we saw that some people were at risk of absconding. For these people the provider had introduced the Herbert protocol. The Herbert Protocol is a national scheme which encourages carers to compile useful information which could be used in the event of a vulnerable person going missing. Care plans we reviewed, had them in place. One relative said, "It gives me comfort and assurance with this protocol in place."

Good

Is the service effective?

Our findings

Information was included in each person's care plan regarding their individual abilities and illnesses. Some people had uncommon conditions and we saw there was detailed information about these to provide staff with the opportunity to understand the impact it had on the person. Any practices or care were delivered in line with current legislation to ensure best practice care was embedded across the home. For example, in respect of cultural and other dietary requirements.

Staff skills had been supported by the training made available. The registered manager had developed a more comprehensive approach to training. This was so that staff not only received the standard areas of training, but had other opportunities to develop skills. For example, positive behaviour support was being implemented. Another staff member told us how they had been encouraged to pursue the next level in their vocational training.

New staff had completed the care certificate. The Care Certificate has been introduced nationally to help new care workers develop and demonstrate key skills, knowledge, values and behaviours which should enable them to provide people with safe, effective, compassionate and high-quality care. One person said, "All training is really good, it covers the things you need to know. "

We saw training was being developed in desensitisation. Desensitisation uses processes to decrease the abnormal fear in a person of a situation or object. This had been developed to help some people understand medical procedures. For example, blood tests or taking blood pressure. This practice had been undertaken with support from a range of health care professionals and family to enable people to be supported in their ongoing health needs.

Positive health care outcomes had been experienced leading to improved quality of life. The health and social care professionals we spoke with all felt that all the staff had people's best interests as a focus. One health care professional said, "Broadly speaking I feel Tarry Hill do a good job in an area of care which is highly complex and challenging. The atmosphere is generally positive." Each person had a personal health file which detailed all their needs. A health care professional said, "They contact us if they have any issues. When I do call, staff are very knowledgeable and helpful. They know people really well." Any information they had provided was included as a guide.

People had been supported to eat and drink enough to maintain a balanced diet. One person told us, "I enjoy the food, we get choices." A relative said, "There is fresh food, [Name] is well catered for." We saw the staff planned the meals with the people in each home and ensured that specific diets had been catered for. For example, one person required Halal meat and this was sourced from a local butcher. Another person needed gluten free food; they had separate cupboard space and items were clearly identified. People's weights had been monitored and when required specialist advice had been sought.

People's individual needs had been met by the adaptation, design and decoration of premises. For example, one person had their own water garden, we saw them using this area and enjoying the space. People's

rooms had been adapted to make them safe, for example, with the appropriate furniture. People had been encouraged to personalise their rooms.

The Mental Capacity Act 2005 (MCA) provides the 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 capacity to take particular decisions, any made on their behalf must be in their best interests and least restrictive as possible.

People were supported to make decisions and direct their own lives and when required, the legal framework of the MCA was implemented. For example, in relation to a medical examination, we saw where the person lacked capacity a best interest meeting had been completed. The meeting involved the GP and relatives to consider if the examination should take place and if so, the impact on the person. A relative told us, "I have been included in supporting the decision process." We saw to enable the medical procedure to occur, staff had taken the person on familiarisation trips to the hospital and on the day, was supported by additional staff who all knew the person well. We saw this process was used for many decisions when people were unable to make them independently.

People we spoke with told us they were supported to make choices, they were provided with information to enable informed choice in a format they were able to understand. For example, easy read. Staff we spoke with had a comprehensive understanding about decisions and the MCA. We saw when some people's capacity had changed this had been reviewed and the required changes made.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions are authorisations to deprive a person of their liberty were being met. When people required a referral, this had been made to the relevant local authority and we saw the registered manager kept a record which was reviewed monthly.

Care plans contained specific information about any restrictions which were also linked to risk assessments. When a person had a DoLS which had been authorised by the local authority we saw that any conditions had been or were being met. The management team were committed to ensuring that people were supported in the least restrictive way possible. The registered manager told us they would review any restrictions to ensure they were still necessary.

Good

Is the service caring?

Our findings

People were treated with kindness. One person said, "I like it here, the staff are nice to me." Relatives we spoke with felt the staff showed compassion for people. One relative said, "The staff are nurturing and they get to know them and understand them." We observed the relationships which had been developed. Staff knew people well and there were positive interactions between them. When it was appropriate, fun and banter was introduced. For other people set routines and language had been observed. A relative said, "Since being here they have become much more confident and starting to take an interest."

People were encouraged to be independent. We saw people were supported with daily tasks, for example, cleaning their own bedroom and supporting in the meal preparations. We saw one person was supported to iron their jeans and another was guided to cut up vegetables for the planned meal. Other people were less able to complete task however they were encouraged in any small way to be part of the home environment.

Following events staff reflected on the events to identify what had been a success and how the experience was for the person. For example, one person had been for a haircut. This was a huge achievement for this person. The staff had taken time to help the person with their understanding and support during the event. Individual events of success had been celebrated and shared with the staff team. For example, one person had pegged out their washing. For this person it was a massive achievement. Other people had achieved long distance walks raising funds for charity. Each person had their own goals which were specific to them.

People's privacy and dignity was respected. We saw staff knocked and announced themselves before entering people's rooms. Another person had a sign on their door, 'Do not disturb' and when in use this was respected. Staff asked people's permission before an activity or when a person required individual support. People were dressed in clothes they had chosen and when these become marked following a meal or wet through an activity people had been encouraged to change. One staff member told us, "We are working towards the local authority dignity award, its good as it makes it a focus."

Relatives were welcome to visit anytime. One relative said, "They are very welcoming and open and transparent." We saw that contact with people of importance had been encouraged and promoted. Some family had set routines of visiting and other people had been supported to visit relatives in their own homes.

Information about people was kept confidential. Care plans were locked in an office and when computers were used they were password protected. When people required support with their decisions we saw that advocates had been consulted. An advocate is a person who represents another person's interests. When an advocate had been involved they were included in meeting and given all the required time and information so they could support the person with their chosen decision.

Good

Is the service responsive?

Our findings

People receive a comprehensive assessment before they moved to Tarry Hill. We saw when one person had to move in very quickly, time was taken to involve those people important to them to support information required to meet the person's needs. A social care professional we spoke with said, "They went above and beyond for this person to make them feel comfortable. They now wish to stay which is a massive decision for them."

Care plans were detailed and personalised to enable staff to have a comprehensive understanding of people's needs. For example, one person's care plan detailed their daily routines. There were two evening routines which showed the changes required in relation to the seasons. Family members had been involved in compiling the details, one relative said, "They value the families input." They added, "We provide the detail in the plans which is a necessity." Professional had also been involved in the care plans. A social care professional said, "They work on the plans and contact for advice and guidance, which they follow."

Care plans had been reviewed monthly or before if a change had occurred. Formal reviews had been completed with health and social care professionals and people of importance to the individual. Some people also had the support of an advocate. Following these meetings any changes were communicated to the team of staff.

The care plans were divided into different sections to cover all aspects of care for people. For example, there was a communication plan, an oral care plan and other aspects of need. We reviewed one oral care plan which showed the staged approach which had been taken to develop the persons sensory understanding in cleaning their teeth. Some of the daily skills had been developed through mirror learning. The mirror learning can be obtained directly from another person through observation or by listening to their comments.

The provider understood the importance of having information in an accessible format. This is referred to as the Accessible Information Standards (AIS). The AIS is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. The staff used a range of methods to communicate with people.

One method which had been tried was the Picture Exchange Communication System, (PECS) this allows people with little or no communication to communicate using pictures. However, the staff found the person required the tangible item to aid their understanding. Other support methods were being used for example Makaton. One relative said, "Staff are using more Makaton which is opening the door of communication." Makaton is a language programme using signs and symbols to help people to communicate. It is designed to support spoken language.

Easy read versions of information were also available. For example, information about epilepsy and other signage around the home. We saw how one person was supported to express their emotions. They had a positive relation with Lego, the staff had developed Lego faces which showed different emotions and

activities. The person used these to assist them in expressing their wishes for example, when they were tired.

People's cultural and diverse needs had been considered. Assessment of people's diverse needs were in relation to the protected characteristics under the Equality Act 2010. People's diversity and sexuality was considered and identified people's personal preferences and how they wanted to be supported. This included information about how people expressed their sexuality.

People had been encouraged to engage in activities which were of interest to them. There was a huge array of activities taking place in each home which were all specific to the individual. Some people were more physically mobile and enjoyed outside activities and connecting with their local community. For example, the local café or shop. Some people attended the gym and exercise classes. Other people enjoyed being supported to take the bus into town for shopping and meals.

Other people preferred activities within the homes, we saw jigsaws which were midpoint of completion and some people had baskets of different activities which they chose. A relative told us, "I bring in art equipment and the staff use them, the staff are really lovely." A health care professional commented, "The care is good and there is a positive impact on people going out."

The provider had a complaints policy which was available to people on the notice board in an easy read format. We saw that when complaints had been received they followed the policy guidelines and a timely response and written correspondence. This included an apology and the outcome of the complaint. The registered manager was also considering how they could report and monitor non- formal complaints.

At the time of this inspection the provider was not supporting people with end of life care, so therefore we have not reported on this. The registered manager told us they planned to develop this area to encourage those people who were able to be given the opportunity to discuss their wishes and preferences in relation to care at the end of their lives.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager at Tally Hill. They had been in post for five months and had already made several changes. For example, they had recruited a new deputy manager who was previously a team leader at Tally Hill. People and relatives related to both these managers in a positive way. One relative said, "They're like a breath of fresh air and have a nice way about them." People we spoke with felt they could openly speak with the managers.

The registered manager had completed some audits in relation the quality and running of the home. However, we saw these were not always effective. For example, each house had their own set of audits. Some actions they recorded had been actioned, for example, the replacement of pedal bins. However, another audit identified a new sharps bin was required in August and there was no evidence to demonstrate this had been replaced. In addition, a new thermometer was required for the fridge and there were no records this had been actioned. The registered manager had a system to review the audits completed in each house, however the actions required, had not always been recorded and followed up. We discussed these with the registered manager and they agreed to review their approach.

We saw that accidents and incidents had been recorded however, the lessons learnt had not always been followed up. For example, one person had left the building unsupported by staff on several occasions, measures had not been considered in relation to the environment and how to reduce the risk for this person. We saw accidents had been reviewed each month, however they had not been reflected on over time. This meant trends could not always be picked up. For example, one person had fallen on several occasions, before they fell and broke a bone. The staff had put the earlier falls down to an increase in outside activity. They had not considered any other possible medical reason. The registered manager told us they would review this person's situation and reflect on how they could record accidents and incidents moving forward.

We had received some notifications in relation to events in the home, however we identified that some incidents had occurred which we should have been notified of. For example, a person receiving hospital treatment after an incident and occasions when people had left the home without the support of staff. A notification is information about important events, which the provider is required to send us by law, such as serious injuries and allegations of abuse. This helps us monitor the service. The registered manager agreed to review the guidance for notifications.

The provider had completed a survey with family members and staff prior to the new manager commencing their role. Many of the results were not positive and had reflected areas were action was required. We could not see if any actions had been taken to rectify the areas of concern. We discussed this with the registered manager who told us they were considering a new survey to reflect the changes over the last 6 months. People had not been supported to consider the care they received and provide feedback. The registered manager and deputy had lots of ideas they wished to introduce so that people's views would be considered. We saw on an individual basis some people had been able to contribute and their comments had been recognised for example in each house in relation to meal choices and activities.

Staff felt supported by the new management team. One staff member said, "It's now completely different, they're great mentors. Their level of integrity is great." They added, "They have the needs of the people at the heart of everything." We saw the registered manager had made changes to how each house was run. They had given each senior team leader the role of running each house. A senior team leader said, "We are now managing each house separately with allocating staff and support. This is much better as you have more control." We discussed the changes with the deputy, they told us, "I am now able to implement ideas I had as a team leader and provide the type of support I feel I would have wished as a senior staff member." Health and social care professionals all related positives in the new management structure. One social care professional said, "They listen to people and what they say." Another said, 'They have a good foundation to drive things forward."

We saw that all the staff involved had looked to establish partnerships with a range of professionals and services. We saw that Tally Hill was part of the community. The local shop and café were familiar places people visited and people had made friendly links within these areas. One social care professional said, "I know they use the local services as I see people in the community." We contacted several professionals as part of the inspection. The local authority had conducted their own monitoring visit of the service in September. We reviewed the action plan they had provided and discussed the areas with the registered manager. They had already acted to address some of the areas, for example they were working on a checklist for agency staff. All those involved felt that people's welfare and wellbeing was at the heart of the service.