

The White Horse Care Trust

Sarsen House

Inspection report

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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 

Summary of findings

Overall summary

This inspection took place on 12 and 13 December 2017 and was unannounced on the first day. This was the first inspection of this location since a change in provider.

Sarsen House is a residential home for adults with learning disabilities; providing accommodation for up to six people. There were six people living at the service during the inspection. Sarsen House is arranged over two floors, with bedrooms upstairs and downstairs, a communal lounge/dining room, a separate dining room, shared bathrooms and accessible kitchen. The bedrooms were spacious and one person had their own small lounge connected to their bedroom. The service has a minibus to support people to access the local community.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. During the inspection we met with the registered manager, deputy manager and care staff. Staff told us that they felt supported by the registered manager and deputy manager. The registered manager and deputy manager told us that they felt there had been improvements in communication within the staff team.

We received feedback from three relatives. One person told us, "There are no negatives at all" and that "There is a good balance between doing ordinary things, like the chores such as recycling or washing up, and the fun things." Another person said that their relative living at Sarsen House "is really well looked after, really happy, it feels like it is their home". The feedback received was positive and praised the staff team for the support they provide.

Six health and social care professionals were contacted for their feedback of the service; three professionals provided information. One professional said, "The team [at Sarsen House] have always been prompt in contacting us when an individual's needs change; as well as if they have concerns, or require advice-" and "The service has been given much advice and recommendations over the years, which has been received and acted upon promptly." All feedback from health and social care professionals expressed that the service provides person centred support.

Support staff sought consent from people before providing support. However, the principles of Mental Capacity Act (MCA) were not always followed when making decisions about people's care and support. Best interest decisions were not reviewed annually for one person. For another person, they had lived at the service for six months, without their capacity being assessed, but with decisions being made for them. When asked, staff were not consistently able to recall the principles of MCA, or relate them to their role.

Audit systems were in place for medicines management. However, the format of the audit was not understood by the person completing them. While areas requiring action were identified, it was not

recorded what the response had been, or when this had been completed. During the inspection, the registered manager liaised with the regional manager to gain support in developing their understanding of this audit process.

Where appropriate, risks had been identified and recorded in people's care plans, with guidance for staff to manage these risks safely. Accidents and incidents were recorded and analysed at the service, as well as at a head office level to check for patterns and trends.

Staff said they felt confident they could ask for more training; and the manager identified that training in MCA was required for all staff. However, there was no overview of the training needs of individuals, meaning that gaps in training could not immediately be identified. During the inspection the registered manager liaised with the regional training manager to plan how this could be improved in 2018.

Each person had a care plan which contained person centred information about the person's life and preferences. The care plans contained paperwork from the current provider and the previous provider, the transfer of information was a work in progress at the time of the inspection. The plans contained one page profiles.

During the inspection there were sufficient staff on duty to ensure three people could attend an art club, one person attended a health appointment and another person was driven to meet with a relative for lunch.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. CQC check that appropriate action has been taken. The management team had submitted notifications where required.

Care plans showed that people had been referred to healthcare professionals promptly when needed. Input received from healthcare professionals was recorded and used in care planning.

There were gaps in recording for one person who required their fluid intake to be monitored, the total fluid intake was not recorded and the fluid intake goal was not written down in the recording system. During the inspection the regional manager implemented a new recording process to incorporate the recommendations made.

Staff understood their roles and responsibilities; they acknowledged there had been challenges in changing providers, but felt that the team was continually strengthening. Staff received individual supervision meetings with the registered manager or deputy manager.

Providers are required, by law, to display their CQC rating to inform the public on how they are performing. The latest CQC rating was displayed in the service and these details were also on the provider's website.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

'As and when' prescription protocols were not detailed or person centred. Information around where to apply prescribed creams was not provided. Medication audits identified where there were errors, but did not identify what action had been taken as a result of this.

Staff understood the safeguarding processes and could identify the types of abuse.

Detailed epilepsy protocols were in place and staff had completed specialised training.

Staff were recruited safely. There were sufficient staff to meet people's needs.

Regular checks were completed, but there was no audit in place to check for legionella.

Requires Improvement ●

Is the service effective?

The service was not always effective.

The principles of the Mental Capacity Act 2005 had not been consistently followed in making, recording and reviewing of best interest decisions.

Staff could not consistently explain the principles of MCA, or explain who at the service was subject to a DoLS.

People's healthcare needs were met with involvement from healthcare professionals. The input provided was used in creating the care planning process.

Requires Improvement ●

Is the service caring?

The service was caring.

Relatives of people living at the service spoke positively about the care their loved ones receive.

Good ●

Staff communicated with people in the way they preferred and were confident using communication tools.

People appeared relaxed and comfortable in the company of staff.

Is the service responsive?

Good ●

The service was responsive.

Healthcare professionals explained that staff involved people as much as possible with understanding and recording their support needs.

Care plans reflected the likes and dislikes of the individual and presented a person centred, easy to read picture of the person.

People were supported to raise concerns or provide feedback in different ways based on their preference. Staff also understood how to identify if a person may have concerns.

Is the service well-led?

Requires Improvement ●

The service was not always well-led.

The registered manager had worked hard to build community links to develop opportunities for people to be socially involved.

There are aspects of the service that are a work in progress at present in enabling the manager to have a full insight into the overall quality of the service.

The manager was knowledgeable and passionate about supporting individuals within the service, including people's specific preferences.

The culture within the home had started to become more positive recently. This change required some time to become embedded into daily practice.

Sarsen House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 12 and 13 December 2017 and was unannounced on the first day and announced on the second day.

The inspection was the first for Sarsen House under the provider White Horse Care Trust and was carried out by two inspectors.

Before the inspection we asked the provider to complete the Provider Information Record (PIR). The PIR is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We reviewed the records we held about the service, including details of any statutory notifications submitted by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

We spoke to three people's relatives, three care staff including the deputy manager, the regional manager and the registered manager. We observed staff carrying out their duties, communicating and interacting with people.

We reviewed four people's care plans, including their risk assessments. Medicine records for three people were also reviewed; as well as four staff files. Policies and audits were checked during the inspection. After the inspection three health and social care professionals provided feedback about the service.

Is the service safe?

Our findings

People's medicines were not always managed safely. There were 'as and when' medicines prescribed in addition to those for epilepsy; however, the protocols for these did not contain specific and person centred information. There were no guidelines for the application of creams. Staff signed in daily records each time a prescribed cream was applied, but it was not clear exactly where the cream was prescribed. People's prescribed medicines sold over the counter, were waiting for the appropriate authorisation from their GP to confirm they were able to use them safely.

Medicines were stored appropriately and securely, with up to date stock checks in place.

Risks to people's health and welfare were identified and assessed. The risk assessments for people living with epilepsy were detailed and when asked staff could confidently explain the protocols in place to support individuals in the event of a seizure. People living with epilepsy were prescribed 'as and when' medicines to control their seizures. The epilepsy protocols had been produced with input from the epilepsy nurse and staff had completed training in rescue medication administration.

The layout of the service enabled people with visual impairments to navigate safely around their home. The registered manager explained that maintaining the same layout in the home, people with visual impairment at the service have been supported to improve independence and become more socially engaged within the home.

Staff supported people to manage their money safely. Staff followed procedures for people who required help from staff with budgeting. When staff made purchases on behalf of people receipts were retained, all expenditure was recorded and balances were checked and signed for by staff.

Each person had a personal emergency evacuation plan (PEEP), so that people could be safely evacuated from the building in the case of an emergency. There was a fire risk assessment in place and regular checks were completed on fire equipment.

Staff identified the different types of abuse and knew who they could contact within and outside of the organisation to raise any safeguarding concerns. Staff were aware of the safeguarding policy and understood their responsibilities within this.

People were supported by enough staff to meet their needs. The staff team told us they felt there were enough staff on duty to meet people's needs in a relaxed and attentive manner. There were sufficient staff available during the inspection to support people to attend activities and appointments, as well as during meal times. The registered manager explained that a system was in place rostering staff members to support different people for the start of their day and during activities; this information was presented on a large white board in the dining room. The registered manager explained that for some people it provided reassurance to be able to see in advance who would be supporting them.

A new handover and shift leader system had been implemented three weeks prior to the inspection. The

registered manager explained this was to aid communication and that it encouraged accountability amongst the staff team.

There were processes in place to maintain standards of cleanliness and hygiene in the home. For example, there was a cleaning schedule which was completed by housekeeping staff and care staff to ensure that all areas of the home were cleaned. All areas of the home were clean and there were no odours present.

People were involved in maintaining the cleanliness of the home. If they wanted to they helped with the cleaning their own rooms and other communal areas. We saw people undertaking cleaning tasks during our visit, under the supervision of a support worker. The staff member asked if the person wanted to help with the vacuuming. They then asked "Are you ready" before switching on the Hoover. They gave the person lots of encouragement by saying "Well done" and "You are doing a fantastic job."

During the inspection we observed staff using appropriate protective equipment, such as disposable gloves and aprons. We observed staff following infection control procedures. Regular infection control audits were completed to assess how the procedures were being put into practice and identify any areas for improvement. The registered manager had recognised a legionella risk assessment had not been completed and was planning to action this.

People benefited from safe recruitment and selection processes. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people.

The service employs agency staff on a regular basis. One page profiles were in place about people living at the service enabling agency staff to read an overview of what is important to the person, their likes and dislikes, as well as any critical care needs.

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The staff we spoke with were not able to relate the principles of MCA to their role, or evidence understanding of DoLS. Staff were unable to explain the decisions they made in a person's best interests when a person lacks capacity, or explain who at the service had a DoLS application in place. The registered manager explained that this was a training need that had been identified for all staff and that the need for further training was understood.

One person had a capacity assessment which did not have a date identifying when it had been completed. A best interest's meeting had taken place in October 2015 but it was unclear if it related to the capacity assessment which had been undertaken. Since the 2015 best interest's meeting, the needs of the person had changed and consideration for this had not been evidenced.

People can be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under MCA. The application procedure for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. A capacity assessment had not been completed for one person who had lived at the service for six months and there was no evidence a best interest's meeting had taken - place. The care plan for this person referred to them as lacking capacity to make certain decisions. This person was being deprived of their liberty without the appropriate legal documentation in place as decisions were being made in their best interests although these were not formally recorded, such as consent to live at the service while receiving care and support.

Prior information for one person living at the service, regarding their capacity had not been sought ahead of their admission. Another person had a detailed admission assessment, including information regarding their mental capacity included in their care plan.

We recommend the provider consider reviewing current guidance on the implementation of the Mental Capacity Act 2005. We recommend that the service finds out more about training for staff, based on current best practice, in relation to the Mental capacity Act 2005.

People living at the home had a 'Health Action Plan', to plan and record any medical intervention required such as optician, dental and doctor's appointments. People were supported to maintain good health and had access to healthcare services as required. There were arrangements in place to ensure people were able to attend appointments and check-ups for all health needs. Contact with health professionals, including the speech and language therapists (SALT) was recorded in people's records. This showed people's day-to-day

health needs were met. The Health Action Plan included age and gender appropriate support information; such as for breast self-examination.

One person's behavioural support plan was reviewed during the inspection. There was evidence of involvement from health and social care professionals in the creation of the plans.

Staff understood individual means of communication and the importance of these for that person when interacting. Three people at the service had developed their own personal methods of communication, combined with speech or Makaton. Staff had sign language (Makaton) communication cards attached to their identification lanyards to support them with communicating with people. One person used a communication book with pictures, this helped them to plan their day with staff and talk about what they would like to do. The registered manager explained that the staff team have been developing their understanding of this communication aid, adapting their approach to support the person's wellbeing. During the inspection staff were seen putting their knowledge into practice when communicating with people.

The induction for new staff was three months, with new starters working alongside an experienced member of the team who acted as their mentor. One staff member currently in their probation period told us they were given plenty of time to read care plans, health action plans, risk assessments and policies. They also advised us that they shadowed shifts but said "Everyone you work with knows the people so well and you know you can check the care plans for any additional information you may need." New starters undertake training such as food hygiene and first aid; there is also more specialist training to support the needs of people living at the service such as epilepsy.

Staff competencies and gaps in knowledge or training were not recorded in a way that would enable the registered manager to have an overview of the needs of the staff team. During the inspection the registered manager contacted the training manager and arranged a meeting to discuss implementing a system to gain insight and an overview of the training needs of individuals.

Records showed staff had the opportunity to discuss their personal development, training needs and working practices through one to one meetings, job chats or team meetings .

People's dietary needs were not always managed effectively. One person had their fluid intake recorded. This was recorded daily, but the goal intake was not identified and the style of recording did not evidence if the person had been offered but declined a drink. The fluid recordings were not totalled each day and there was no overview of any progress or patterns. This meant that staff were not appropriately responding to the assessed healthcare needs of the person.

During the inspection staff were preparing the lunch time main meal, staff prepared the meal to account for SALT guidance by removing skins from sausages for one person. People were not offered choices for their meal, everyone had the same. Gravy was added to each plate of food without the choice being offered. Staff were not consistently able to explain what input people had in deciding what food would be served at main meals or available in the home. One staff member told us that if a person decided they did not want the main meal they could choose to have an alternative.

We observed during the lunchtime meal that one person's request for more food went unnoticed by staff. The person eventually went into the kitchen and brought the vegetables to the table. The staff member still did not recognise the cue from the person that they were still hungry. They eventually supported the person to have more vegetables. This also led to the person trying to take food off someone else's plate which caused the person some upset.

People were offered drinks and those who were able to were supported in the kitchen to prepare hot or cold drinks of their choice.

We observed the lunchtime meal and staff were supporting people to eat. Staff spoke to people while they were supporting them and worked at a pace appropriate to the person. People were sitting at three different dining tables in the communal areas, staff explained that this was because two people were more active and vocal during their meal, one person preferred to eat at a table in the kitchen, and the other people preferred a quieter meal time.

The staff team worked together efficiently throughout the inspection. Staff appeared aware of their responsibilities and what needed to be done. The agency staff member was communicating with the staff team to check information when required.

Is the service caring?

Our findings

People were supported by staff who were patient and took their time with them. People were not rushed and care and support was offered at a pace appropriate to them. For instance, one person was being supported to walk from their bedroom to the communal lounge. Staff walked with the person at their pace, offering encouragement and guidance. They told the person what was happening and encouraged them to be as independent as possible. Once seated they checked the person was comfortable and offered them a drink of their choice.

People's request for support was responded to by staff. For example, one person required support to put on a film of their choice. Staff responded to their request for help, checking which film they wanted to watch before putting it on.

People were supported by staff who knew them well. Staff were able to tell us about people's life stories and history and about the people who were important to them. Staff had a caring and compassionate approach to their work with people. They knew people well and demonstrated an understanding of the preferences of the people they supported. This included what their preferences, likes and dislikes were. Staff had developed caring relationships and we observed staff communicated with people in a warm, friendly and sensitive manner that took account of their needs and understanding.

One healthcare professional told us "There is always privacy for the person's review held in the house and any sensitive information which may cause anxiety to the individual is discussed away from them".

People were at ease with staff and their surroundings. People moved freely around the home choosing to sit in the communal areas or go to their bedrooms. People's needs and preferences had been taken into account to ensure their bedrooms reflected these and were personalised. Staff knocked and sought permission before entering people's rooms.

People's bedrooms contained items that were important to them. One person had an electric keyboard which formed part of how they communicated with staff through the use of music. Staff communicated with people in ways that were personal to the individual, using communication tools and their understanding of that person. The weekly plan was displayed in the dining room, people referred to this during the inspection to help them plan their day.

Relatives told us they felt the staff team are caring and supportive. One relative said, "there are no negatives at all" and that they felt confident the care was person centred, with lots of activities and things to do.

The registered manager explained that one person's favourite colour was orange. Together they visited a local café and the café had specifically ordered chocolate bars with orange wrappers for this person.

People's care plans included sections with easy read or pictorial guidance to encourage people to be involved in the planning of their care. Decision making profiles were in place in the care plans, including

examples of day to day decisions such as making medical appointments, with how the individual person may respond or indicate their decision.

Is the service responsive?

Our findings

People received their care, treatment and support when they required it. Staff interacted positively with them and responded to their needs. For example, one person requested a drink because they were thirsty. Staff responded promptly asking them what drink they would like. They asked the person if they would like to help make their drink and respected their choice not to.

People's care plans were written using person centred terminology and reflected physical, emotional, mental and social needs. Daily records were detailed and included information about the tasks, as well as the social and wellbeing aspects of the person's day. The care plans also contained examples of people's usual daily routines, choices and preferences they may make throughout the day.

One person had lived at the service for a substantial number of years, however there was no life history recorded in their care plan, despite part of their life history being spent at the service.

People were supported to be involved in the local community and to meet their personal and religious needs by attending the local church services. A relative said that people "go swimming, attend music sessions, visit the local towns, there is always something to do."

One person had recently been using a tricycle and staff explained that they were looking for enjoyable locations where the person could experience the increased physical independence the tricycle could bring. Staff had been supporting the person to use the tricycle in the village.

While the service was located in a rural village setting, staff utilised the minibus and community links to provide a varied activity programme with social engagement for each person based on their individual likes and needs. People were supported to maintain relationships with people that mattered to them. On the first day of the inspection three people attended a local art club and one person, with staff support, met a family member for lunch. The registered manager explained that one person attending the art club may chose not to attend each week, but liked to attend when they knew their friend would be there. During the inspection one person who had stayed at home on the first day, was being supported to go to a coffee shop in the morning of the second day. The staff member explained that this was something the person enjoyed doing.

People had access to a complaints policy and process in place to ensure that any concerns raised were dealt with effectively. No complaints had been raised since our last inspection. The complaints process was available in accessible formats for people. There was an easy read, pictorial document or people could watch a DVD of how to complain if they wished. One person chose to have regular meetings with the registered manager; this was one to one time to discuss any concerns, feedback, or other topics of their choice.

Staff explained how they might be able to recognise if a person wished to make a complaint but were unable to verbalise their concerns. One staff member told us "for some people they may need to show us or take us to what the issue is, for other people we might ask them to write it down". Staff understood the

importance of confidentiality and the different ways in which complaints can be made.

The service was not currently supporting anybody with end of life care. However, the registered manager and area care manager acknowledged that this was an area that needed some development. They said people's preferences and their choices for how and where they wished to be cared for during illness and end of life care needed to be identified with the person and those who knew them well and recorded.

One health and social care professional said, "People are always present for any review and staff encourage as much participation as possible".

Is the service well-led?

Our findings

There was a registered manager in post; the manager was supported by a deputy manager who had joined the team at Sarsen House five months prior to the inspection, from another home within White Horse Care Trust.

The quality of the audits completed were variable. The medication audits identified when gaps in medication administration recording had occurred. However, the process did not identify what action had been taken as a result of this and to prevent this from reoccurring. The audit tool - did not identify that for one person medication had been signed out to take outside of the home, this medicine was not administered and was not signed back in. The registered manager had a list of audits that were to be completed monthly, including those for health and safety; medication; DoLS applications and authorisations; and an audit of staff training needs (training matrix). A training matrix was not in place at the time of the inspection.

Although the registered manager was involved in the day to day running of the home, processes were not yet fully embedded to enable the manager to have an up to date and detailed insight into the quality of the service provided as a whole. The registered manager was aware of the areas where a clearer overview would be beneficial, such as the training matrix, and was receptive to feedback to aid further service improvement. Due to the changes in provider and developing into the role, the registered manager understood that there were areas of the service requiring improvement and these had been identified in a service improvement action plan. When asked about challenges, the registered manager explained that the biggest challenge they experienced was "trying to get everything fully up together that I need."

There were some processes in place to monitor the quality of the service. However, the registered manager explained that they were currently looking at ways in which feedback could actively be sought from relatives, stakeholders, and other professionals. The feedback currently relied on relatives coming forward with any concerns or issues they might wish to discuss; but this did not enable the registered manager to gain an overview of what people outside of the service felt is going well, as well as areas that could be improved.

Staff attended team meetings and people using the service would occasionally choose to join these as well. The meetings took place regularly every six weeks, with notes detailing required actions made available.

There was mixed feedback from the staff team regarding the culture and team dynamics within the home. However, all staff explained that this had recently improved and that due to staffing changes and new practices being further embedded, the culture within the home was becoming much more positive. One member of staff said, "Personally I think the team is a bit all over the place, there can be a divide, but recently the atmosphere is light and more relaxed. Our team work has improved and will continue to do so." The registered manager said, "We do address staff morale in team meetings and communication updates. It feels like we are pulling the team back together now." The registered manager recognised that this has been an area where improvement was required in the development of the service.

During the inspection staff spoke positively about the registered manager and the deputy manager, explaining that they would feel confident asking questions, providing feedback, or discussing any concerns.

The registered manager explained that recruitment could be challenging because of the location of the service and the limited public transport links. Positions were advertised locally and the team were supported by the use of agency staff. When recruiting new staff, the manager would invite the candidate to join them for lunch or an activity, prior to the formal interview, the manager explained that this enabled them to see first-hand how people reacted to the candidate and allowed them to demonstrate their skills.

Within the local community, the registered manager explained that links had been built with the church, with people choosing to attend services locally. People were encouraged to attend activities such as swimming, arts and crafts clubs, music sessions; or seasonal activities such as watching a pantomime. The registered manager knew people's specific likes and personal preferences, such as who preferred which activity and which people preferred small group sessions.

The registered manager was currently completing the Level 5 Leadership in Health and Social Care diploma and explained how the qualification had developed understanding of reflective practice, introducing this into team meetings to discuss lessons learned when challenges had occurred.

Health and social care professionals spoke positively about the management of the service. One professional said, "Managers are always very informative keeping us up to date with any changes to people's health needs." One professional also gave an example of how the service had responded well and learned from challenges they had experienced: "They are always open to advice and comments on the most effective way to manage people's needs, particularly in the early stages with the new provider, there had been changes to the layout of the house, which had a detrimental effect on two of the people living there – they immediately put things back to the way they were."

There were plans for staff to visit and spend a day working at other services within the organisation to enable them to see how the changed processes could be beneficial once embedded into the care practice.

Providers are required by law, to display their CQC rating to inform the public on how they are performing. The latest CQC rating was displayed in the service and these details were also on the provider's website.