Threeways Care Limited

Threeways

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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This was an unannounced inspection that took place on 18th November 2015.

Threeways is a residential care home for 6 people who have a learning disability, autism and behaviours that can challenge. People have varied communication needs and abilities. Some people are able to express themselves verbally using one or two words; others use body language to communicate their needs. At the time of inspection there were five people living at the service.

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 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.

This is the first inspection since the provider changed its legal entity.

Summary of findings

People were not always safe at Threeways. There were times when there were not always enough staff deployed to meet the needs of people. Some people were assessed to have 1:1 staff support. The provider told us "we sometimes do group sharing." This means that people were sometimes grouped together for activities when there was not enough staff to provide 1:1 support.

Incidents and accidents had not been recorded appropriately. The incident and accident folder did not contain any forms; the provider stated "We do not have any incidents or accidents."

Staff had some knowledge of safeguarding people and told us what they would do if they had a concern. They knew to report it to the registered manager or to the local authority.

Risks to people had been assessed, however one person had been identified as a risk of choking. Surrey's choking policy had not been followed, as the registered manager had not made the appropriate referral to the Speech and Language Therapist. The provider made the referral on the day of inspection.

There were robust checks in place to make sure that staff were suitable before working in the home. Medicines were stored safely and people were given their medicines at the right time in a safe way.

We found the provider had not always met the requirements of the Mental Capacity Act. Peoples consent was not always sought about what care and support they needed. We saw staff leading people around the house by holding onto their wrists or hands.

Some mental capacity assessments had been completed regarding people being able to leave the home and accepting care and support. Relatives and relevant health and social care professionals had been consulted on these decisions.

Staff were not always sufficiently trained to support people. Most staff had not received specific training or had a refresher in current practises in working with people with autism, communication difficulties and physical interventions.

People had access to health professionals such as psychiatrists, dentists, GPs and opticians to ensure their health and wellbeing was maintained. People had enough to eat and drink, but people did not always have a choice as to when they could have it or what they wanted.

The service was not always caring. People were not always involved in making decisions about their care. People did not have individual goals to allow them to develop their skills and life opportunities. People had person centred and care plans in place.

Staff were not always interacting with people in an age appropriate manner; phrases like "good boy" were common place. People's dignity and privacy was not always respected. Staff did not always knock on people's bedroom doors.

People did not always receive individualised care that was tailored to their needs. People's activity timetables were very similar and people did in house group activities together. There was little opportunity to participate in activities out in the community.

A relative told us "We are very pleased our relative is there, it is the best home they have been in, it's family orientated." Another relative told us "The family environment the service offers was very relaxing and had helped him in many ways." Staff supported people to maintain relationships that were important to them.

We observed an activity outdoors; the staff member engaged with the person about road safety, nature and plans for later that day. Staff treated people with kindness and compassion.

There was a complaints policy in place; the registered manager told us that no complaints had been received by the home. However the complaints policy was not on display around the home for people or relatives.

The registered manager and the provider spent most of their working week supporting people. This does not allow them time to develop the service and to drive improvements with regards to staff practise. There were quality audits in place, but they were not always effective as they did not identify any of the areas that have been identified in the report.

Staff told us that they felt the manager was approachable. Staff received regular supervision and there were regular staff meetings.

Summary of findings

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 this 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?

Requires improvement

The service was not always safe.

The provider had not always ensured there were enough staff deployed to meet the needs of people.

Risks to people had been assessed but not always managed appropriately to keep people safe.

Staff had knowledge of how to keep people safe.

There were robust staff recruitment checks in place to make sure they were suitable before they started work.

Medicines were managed, administered and stored safely.

Is the service effective?

Requires improvement

The service was not always effective.

Mental capacity assessments were not always completed. Consent was not always sought about the care and support people needed.

Staff training was not always up to date and specific to meet people's individual needs.

People had enough to eat and drink to maintain good health. People did not always have choice as to what to have and when they could have it.

People were supported to attend healthcare appointments and staff liaised with other healthcare professionals as required.

Is the service caring?

Requires improvement

The service was not always caring.

People were not always involved in decisions regarding their care and support.

People were not always treated with dignity and respect. Interactions with people were not always age appropriate.

Staffing was consistent and staff knew peoples preferences, likes and dislikes.

Is the service responsive?

Requires improvement

The service was not always responsive.

People did not always receive individualised care that was tailored to their needs.

People did not always have choice about what they wanted to do.

There was a complaints policy in place; however it was not available for people or their relatives.

Summary of findings

Staff supported people to maintain relationships that were important to them.

Is the service well-led?

Requires improvement 

The service was not always well led.

There were some quality assurance systems in place however they did not always identify improvements needed.

The culture of the home did not always enable people to take positive risks to develop their independent living skills.

The provider had over sight of the day to day workings of the home.

Staff received support and supervision.

Threeways

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 18 November 2015 and was unannounced.

The inspection team consisted of three inspectors.

Before the inspection we gathered information about the home by contacting the local authority safeguarding team, care management and quality assurance team. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During and after the visit, we spoke with two relatives, the registered manager, the nominated individual, and two members of staff. We spoke with two relatives and two health care professionals. We spoke with two people and we spent time observing care and support.

We looked at two people's care records, medicine administration records, staff rotas, and two recruitment files for staff, supervision and training records. We looked at mental capacity assessments and Deprivation of Liberty (DoLS) applications and authorisations for people. We looked at records that related to the management of the service. This included minutes of staff meetings and audits of the service.

This was the first inspection of the service since its change in legal entity.

Requires improvement

Is the service safe?

Our findings

One relative told us "There are no problems with staffing; X has one to one staffing when he goes out." However we found that there were not always enough staff deployed at certain times to always meet people's needs.

We were told by the provider that three people needed one to one support from staff at times during the day; this level of staffing had been assessed by and confirmed to us by the local authority that funded their care. The provider had not completed their own assessment of people's dependency to determine if there were enough staff to keep people safe. The provider told us that there should be four care staff on duty during the day and two care staff at night. They included themselves and the registered manager on the staff rota. On the day of inspection there were four staff including the registered manager and the provider supporting people. The provider told us that they did not use agency staff to cover any staff absences such as annual leave or sickness. As a result when there were periods of annual leave there were less staff working than was needed. After reviewing the staff rotas we found that for a ten day period in November when the provider and registered manager were on holiday there were only three care staff on duty during the day. This was less than the required number needed to keep people safe and meant that people may not have been able to have all their care needs met.

We recommend that the provider reviews staffing levels particularly during planned annual leave or unplanned staff absences.

It was difficult to assess how staff responded to incidents as the details of staff responses were not recorded. However, there was evidence that the frequency of people's challenging behaviour was recorded and discussed on a regular basis with the relevant professionals at the community learning disability team.

There was a safe guarding policy, although it was not up to date with the changes from the Care Act. Staff have had training is safe guarding, however the providers training tool told us that the majority of staff have not had a refresher for over three years. Due to the recent changes in safe guarding law, staff may not always be aware of changes in current knowledge and practise. Staff told us they knew about types of abuse and where to report it. Staff said they would report it to the manager and knew to contact the local authority if they needed to. There was no information displayed in the home for people or visitors to refer to if they needed it.

The appropriate checks were carried out to help ensure only suitable staff were employed to work at the home. There were systems in place to ensure that staff employed were of good character, which included Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Risks to people had been assessed but were not always managed appropriately to keep people safe. One person had been identified as being at risk of choking when they were eating. This information was obtained from their care plan. There had not been action taken to minimise the risk of this happening as there had not been an appropriate referral made to the Speech and Language Therapist (SALT) team. The provider made the referral to the SALT team on the same day of inspection.

Detailed risk assessments were in place; however they were not always reviewed on a regular basis. Risk assessments had been completed for people when they participated in activities. People had risk assessments in place for keeping people safe at home for example people attending to their personal care and for keeping people safe in the community. There was an environmental risk assessment in place which identified risks such as trips hazards and how staff should minimise the risks.

People had a personal emergency evacuation plan in place and staff knew how to support that person if and when an emergency arose.

People's medicines were managed and administered safely. There were no gaps in the medicine administration records (MARs) for all medicines, so it was clear when people had been given their medicines. Each person had a record of PRN medicines and the protocol to show staff how, when and why they should administer it. PRN medicines, can be taken as required, for example for pain relief. The ordering, storage, recording and disposal of medicines were safe. There was a recent pharmacy audit which did not highlight any concerns. All medicines were accounted for and signed in appropriately.

Requires improvement

Is the service safe?

The home had an 'Away from home policy' for people when they visited their families which had clear documentation about taking their medicines safely whilst away from the home. Where people needed to have their medicines administered in a specific way this was agreed with the GP and documented that it was safe to do so. For example one person had swallowing difficulties and needed to have their medicines crushed.

Requires improvement

Is the service effective?

Our findings

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

People's human rights could be affected because some of the Mental Capacity Act were not always followed. Peoples consent was not always sought about what care and support they needed, wanted or when they wanted it and what choice of activity were available. We observed staff direct people using statements such as "It's time to go to your room now." We saw staff leading people around the house by holding onto their wrists or hands. Staff also put their hands on the person's shoulders to move them around the home which meant they did not always have a choice about where they were going or why. Peoples care plans did not always reflect that level of staff intervention. Mental capacity assessments were not carried out for this type of care and support.

Not acting within the requirements of the Mental Capacity Act 2005 is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had completed mental capacity assessments and best interest decisions regarding people being able to leave the home and accepting care and support from the carers. The provider had ensured that family members and relevant health and social care professionals had been consulted with regarding these decisions.

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 the Deprivation of Liberty Safeguards (DoLS). One person has a standard authorisation in place and the home met with its requirements. Applications for DoLS had been submitted by the provider to the local supervisory body for the four other people.

Staff did not always have the skills necessary to support people. We found that staff were not always trained or suitably skilled to meet the needs of people with autism or those with communication difficulties. Some people used Makaton to communicate (Makaton is a language programme using signs and symbols to help people communicate) however not all staff had received training in using Makaton or training in autism. We did not see staff use Makaton to communicate with people. The provider showed us their training tool which identified which staff member had what training and when it was completed. Other training that staff needed to give them the skills and competency to support people were not up to date. For example in areas such as food hygiene, safe guarding, first aid and moving and handling.

Two people's care plans stated that they may need staff to physically intervene if they displayed behaviour that challenged others. Staff had not had any training in relation to this which meant that people may be at risk of inappropriate or unsafe physical interventions. The provider told us that they "Did not believe in the use of physical intervention" and that it was not practised in the home.

The registered manager and the provider told us they provided regular teaching sessions for staff; the most recent was on positive behavioural management. The registered manager also told us that one staff member was currently undergoing training with the local authority to become an autism champion.

Staff told us that they received regular supervision with the registered manager and were supported to obtain further qualifications. Staff were undertaking the Care Certificate. This is a certificate that sets out standards and competencies for care workers. Another had completed Level Two in Health and Social Care, which is a recognised qualification for care workers. When new staff started they received an induction into the home.

People were supported to eat and drink enough to maintain their health. We observed lunch and saw people were offered drinks, staff knew peoples preferences. The registered manager told us that a menu plan was drawn up monthly and discussed with people at Threeways. The provider told us the menu was available in pictorial format. The atmosphere was calm and quiet whilst people were eating. People appeared to enjoy the meal of sandwiches and crisps. Staff were sat at the table with people and supported them when they needed help. People were weighed on a monthly basis to ensure that any weight loss

Requires improvement

Is the service effective?

or weight gain would be identified early and acted upon. One person has lost some weight in recent months; the registered manager had requested a GP appointment for this person to discuss their weight loss. As a result the provider told us the GP had no concerns about their weight loss.

People were supported to remain healthy and have access to a range of healthcare professionals. One relative said that "I don't have a worry; if my son is unwell then they will take him to see the GP." We saw evidence in peoples care plans of reports from psychiatrists, GPs, dentists, and opticians. One health care professional told us "They carried and provided all necessary information to facilitate a mental health review and a best interest discussion around use of psychotropic medication."

Requires improvement

Is the service caring?

Our findings

One relative told us they were "Very pleased our relative is there, it is the best home they have been in, it's family orientated." Another said "The service is fantastic it has helped rebuild my relationship" and "The family environment the service offers was very relaxing and had helped him in many ways." Another health professional said "People seem happy; the staff are nice and caring."

People's dignity and privacy was not always respected. We also saw staff walking in and out of peoples bedrooms without knocking or asking the person if they could come in. Staff did not always use language that was appropriate or upheld their dignity. Staff were heard to say "Good boy" frequently to people and "If you need to go to the toilet, I will be with you in a minute" which was said in front of everyone. We observed people in the lounge during our inspection but found that, staff sometimes spoke to people in a direct manner. We heard staff say "Go to your rooms" and "Sit on your sofa."

People were not always involved in their care. People did not have regular meetings with staff to discuss their care and support so did not always have the opportunity to discuss what they wanted to achieve, explore their interests or plan their goals. Peoples care plans did not contain information regarding people's objectives or what skills they would like to develop. There is a keyworker system in place which has enabled staff to develop positive relationships with people.

Relatives told us that they had been involved in the care provided and said the home contacted them regularly to keep them updated. People were supported to make day to day decisions regarding their care, such as what clothing they would like to wear and what food they would like to eat.

We observed an activity outdoors and saw staff engaged well with the person about road safety, nature and plans for later that day. Due to good staff retention, staff were consistent in supporting people and had developed good relationships with people. Staff knew people well; they could explain people's preferences and their likes and dislikes. People were well dressed and their appearance was maintained by staff. For example, with appropriate clothes that fitted and nicely combed hair which demonstrated staff had taken time to assist people with their personal care needs.

The atmosphere in the home was calm and people seemed generally happy and engaged with staff. We heard the registered manager and provider regularly ask people how they were. Relatives could visit their family member at any time. Staff supported people to maintain relationships that were important to them. For example, one person was supported to re-build their relationship with a relative that had broken down. The person now sees their relative on a regular basis.

People were not always supported to maintain their independence. We saw that staff missed opportunities for people to do things for themselves and increase their independence. One member of staff said; "I will bring you a cup of tea" rather than encourage the person to make a drink for themselves.

Requires improvement

Is the service responsive?

Our findings

People were not always supported to develop their skills or to take part in the social activities of their choice. One relative told us "X doesn't like too much activity, they do their best." One person showed us their photo album and said their holiday was "Good." Another person told us "I went to the shop to buy this (a magazine)."

The home had a sensory room which was located in a large wooden shed in the garden. We were told that people did not like to use the room and that it was very cold. People had timetables that highlighted which activities each person did each day. These were in written format with no pictorial plans available for people that were unable to read. People's activity timetables were all very similar and not individual to them. The provider told us that activities were set and were mainly focussed around the group rather than individuals.

People were not always able to access activities that took place in the community. This meant that people were not always able to develop their independent living skills or engage in meaningful activities. A group badminton session was run weekly; however staff told us that one person would rather spend their time playing football; this was not explored further so they were not able to participate in what interested them.

We observed a communications skills group which used picture cards for people to respond to. One person answered quickly but was frequently asked by staff to give others a chance to participate. This person lost interest as a result. One person was able to read and write, however they were not encouraged by staff to do so. The group activity was not tailored to individual's abilities or needs. People are able to communicate what activities they would like to do, for example one person has requested they would like to attend college. However this opportunity has not been explored thoroughly.

Not supporting people in a person centred way is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans contained a person centred plan that was individual to the person. There was evidence that health professionals, families and care managers had been involved in planning peoples care. Care plans contained relevant information such as peoples past medical history but not all had been regularly reviewed to ensure they reflected the person's current needs. Peoples care plans gave details about behaviours that may challenge and how to support the person when they presented with behaviours that challenge.

People had health action plans (HAP) in place which is a personal plan about what people need to do to stay healthy. We were told by the provider that they were reviewed annually. People's behaviour that they had displayed was recorded via a tick chart. One care plan detailed what night support they required and what support they needed in the community which had not been reviewed for a year. Care plans need to be reviewed regularly to ensure people receive the right support.

One relative told us that "I feel comfortable to make a complaint but there has been no need." There were no complaints in the complaints file; the registered manager confirmed that they had not received any complaints. There was a complaints policy, although it was not on display and there was not a pictorial version available for those who required it.

Residents meetings were held on a monthly basis. People decided where they wanted to go on holiday in the summer. There was no opportunity or discussion for people to go on holiday individually. Since the inspection the provider has told us that "People are not able to go individually due to their complex needs as well as their safety and the safety of the staff and people in the community."

Requires improvement

Is the service well-led?

Our findings

There was a lack of effective auditing systems in relation to improving the quality of the care and support. An audit was completed in February 2015 that reported on training, supervision; care plans and safety. However, the audit did not identify areas that required improvement, such as the areas that have been identified in this report. The auditing process is not robust enough to drive improvements forward in quality of care.

The provider did not record the details of incidents and accidents. The provider did not follow their own policy on recording of people's behaviours that challenge others. The provider's policy on prevention and management of challenging behaviour states "that all incidents of challenging behaviour must be reported immediately via the organisation's incident reporting system." The provider told us they "Do not have any incidents or accidents." We asked to see the incident and accident folder, but it was not provided. Since the inspection the provider has told us they have a record of incidents and accidents but it was still not provided. By not appropriately recording the detail of the incidents and accidents meant that the provider may have missed the opportunity to identify trends and learn from events.

A health and safety audit had been completed, this meant that the risks in the home were managed well and people were kept safe. Audits had recently been undertaken for medication, fire safety and cleaning. An external Pharmacist had recently audited people's medication and the storage of and found everything to be correct, with no recommendations.

The registered manager said "The people are at the centre of what we do, we get feedback from relatives, professionals and staff and we listen." However, the provider had not always routinely obtained feedback from people, families and others involved in peoples care. A survey to obtain people's views was undertaken a year ago; it stated that people were "generally happy" living at the home. A staff survey that was undertaken in November 2014 stated that "Staff were generally happy." There were no systems in place to routinely obtain feedback from other people involved in their care, such as professionals. Surveys were not regular and did not capture detailed information, this meant the opportunity to listen to people, staff and relatives to improve the quality of the service was missed.

Staff were involved in the way the service was run. A staff member told us "Yes I am involved in care planning." We saw evidence in people's care plans that staff had been involved in people's care plans. Relatives were not routinely involved in the running of the service. There were no relatives meetings. The provider and registered manager knew the people and the families well. We observed the provider interact with one relative in an open and professional manner. Discussions included the inspection, how the person was doing and what plans they had for the rest of the week.

Discussions with staff, observations and evidence in records confirm that the culture of the home was task focused and did not always enable people to take positive risks or increase their independence. The registered manager and the provider spent most of their working week supporting people. This did not allow them time to develop the service and to drive improvements with regards to staff practise. However the provider and registered manager had management oversight of the day to day tasks of the service.

Staff and relatives told us that the registered manager and provider were approachable and supportive. Staff meetings occurred monthly and learning sets were included each month such as positive behavioural support. The provider and registered manager had a good understanding of their requirements of the Health and Social Care Act 2008 and the regulations. The registered manager had ensured that appropriate and timely notifications had been submitted to CQC when required and that all care records were kept securely throughout the home.

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 9 HSCA (RA) Regulations 2014 Person-centred care **People did not always receive care that was person centred care and tailored to their needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Consent was not always obtained for how people would like to receive their care and support.**