Really Flexible Care Limited

Penniston Barn

Inspection report

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Bedfordshire
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Tel: 01525873265

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Inadequate**
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 inspection took place on 22 and 23 October 2014 and was unannounced.

We had received information of concerns and based on this information we had decided that an inspection was required to establish whether the concerns were legitimate and whether people were at risk. We raised a safeguarding alert to Central Bedfordshire Safeguarding Team. We spoke with the local authority about this service.

Penniston Barn is a care home that provides accommodation and personal care for up to six adults with learning difficulties. On the day of the inspection, there were five people living in the home.

There was a registered manager at the time of our inspection. 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.

Summary of findings

The recruitment procedures were not effective. People were put at risk because Disclosure and Barring Scheme (DBS) checks had not been carried out before staff were able to provide personal care. There were insufficient numbers of suitably qualified, skilled and experienced members of staff on duty to meet the needs of people.

People's dignity was not respected. Although people were treated with respect, there were practices that did not promote and respected their dignity. Information about the safeguarding procedures and how to report any allegations of abuse outside the service was available.

The changing needs of people had not been reflected in their care plans and therefore up to date information was not available to staff when supporting people in meeting their needs. Where people were experiencing behaviour that challenged others, the help, support and advice of other health care professionals had not been sought.

People were put at risk of harm or injuries because the premises had not been safely maintained.

The management did not promote a culture of learning or reflective sessions following incidents to prevent recurrence.

We had issued a warning notice and we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Regulations 2014. 'You can see what action we told the provider to take at the back of the full version of the report.'

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were cared for in an environment that had not been reasonably maintained to ensure that people were safe from any harm or injury.

Recruitment procedures were ineffective.

Risks to people were not managed and mitigated.

The systems for the safe keeping of medicines were ineffective.

Staff were aware of their responsibilities to report any allegations of abuse to the relevant authorities.

Is the service effective?

Requires Improvement

Aspects of the service were not effective.

Staff members had not been provided with the required training and therefore they and people who lived in the care home were at risk of injury and poor care.

People did not access the support of appropriate health care professionals in the management of their behaviour that challenged others.

There were insufficient numbers of suitable qualified, skilled and experienced members of staff on duty to meet the needs of people.

Staff had received training in Mental Capacity Act, completed an induction programme and received regular supervision.

Is the service caring?

Requires Improvement

Aspects of the service were not caring.

People's dignity had not been respected.

Staff treated people with kindness and compassion. Staff interacted with people in a caring way.

Staff were aware of maintaining confidentiality and that they only disclosed information about people who were involved in their care such as their parents, GP and other health care professionals.

Access to advocacy services was available to people when required.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive.

People's changing needs had not been reflected and updated in their care plans so that they needs were met appropriately.

Summary of findings

People had a programme of planned activities.

Complaints were recorded, investigated and responded to.

Is the service well-led?

Aspects of the service were not well- led.

Appropriate actions had not been taken following incidents involving people and staff to ensure that it did not happen again. There was no learning culture or reflective sessions to ensure that staff had a debriefing after an incident.

The views of those acting on behalf of people had been sought and acted on.

Requires Improvement

Penniston Barn

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 22 and 23 October 2014 and was unannounced. The inspection team was made up of two inspectors.

Before the inspection we reviewed the information we held about the service. We looked at the reports of previous inspections and the notifications that the provider had sent to us. A notification is information about important events which the provider is required to send us by law.

We met the five people who lived in the home. However, they were unable to communicate verbally with us so we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the parents or representatives of the people, five care staff, the registered manager, the training co-ordinator, the team leaders and a social worker. We looked at three care records, five medicine administration record (MAR) charts, five staff files, training records and the duty rotas. We also looked at other records which related to the day to day running of the service such as incidents and accidents records, minutes of meetings and quality audits.

Inadequate

Is the service safe?

Our findings

We found that people were at risk of being unsafe and their health and welfare needs were at risk of not being met because the recruitment processes that had been followed were not robust. We found that four of the five members of staff who had been recently recruited had no previous experience in care. We noted from an application form that reasons given for leaving their previous employment was recorded as 'unsuitable' and 'working with miss-behaved children'. We did not see any evidence that the provider had sought an explanation or clarification on the reason given in the application form.

We also found that a member of staff who had been interviewed on 01 September 2014 had started work on the 03 September 2014 without the provider having carried out the Disclosure and Barring Scheme (DBS) checks. The DBS service provides criminal records checking to help employers make safe recruitment decisions. We saw evidenced that the same member of staff had accompanied at least two people on an outing unsupervised and had delivered intimate personal care to them. This demonstrates a risk that this member of staff was not checked as fit to work with vulnerable people prior to providing personal care to them. There were gaps in the work history for three members of staff which had not been explored. A full work history with written explanation for gaps in employment had not been obtained and satisfactory evidence of conduct from previous employment had not been sought. By not obtaining an explanation or clarification, the provider had put the people at risk of exposing them to staff who might not be suited to care for them.

This was in breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people had not been managed appropriately. We looked at the care records for three people. We found that one person had showed behaviour that put others at risk. During one month there had been eight incidents recorded. These incidents involved staff being hit, their hair pulled and kicked and the person had to be restrained to prevent harm or injury to their self and others. We checked whether there was any guidance for staff to manage and de-escalate such behaviour. There was no guidance available for staff on how to manage this person's behaviour. The incident and accident forms completed following these events had a section asking staff to detail the risk and how to mitigate this risk in the future. These forms were not completed correctly and the risk was not being identified and no plans were put in place to mitigate the risk in the future. The only information available to staff was that this was 'known behaviour'. The staff we spoke with said that such behaviour occurred regularly and it was accepted and dealt with incident by incident rather than ensuring that risks of harm and injuries were managed and mitigated.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The premises had not been reasonably maintained to ensure that people were not exposed to risks of harm or injuries. We found that electrical wires connecting to the refrigerators in the kitchen and in one of the people's bedroom were exposed from their protective casing and posed a risk to people if touched. These also presented a fire safety risk. We saw uneven floorings which meant that people and staff were at risk of falling and injuring themselves. The carpets on the stairs were baldy worn and stained which meant that people, staff and visitors were at risk of slipping and sustaining an injury.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service followed the local authority safeguarding procedures. Information on how to contact other relevant bodies outside the service was displayed on the notice board. Staff had received training in safeguarding and were aware of their responsibilities to report any allegations of abuse to the manager and outside the care home. The manager said that they had reported incidents of concerns to the safeguarding team and had notified the Care Quality Commission as required by legislations.

We found that controlled drugs were not stored in a metal cabinet or safe as required by The Misuse of Drugs and Misuse of Drugs (Safe Custody) (Amendment) Regulations

Inadequate

Is the service safe?

2007. This was important to ensure that unauthorised people did not have access to the controlled drugs and therefore added measures were required. We noted from the records that where controlled drugs had been administered, these had been witnessed and signed by two members of staff and a total of all medicines remaining had been recorded appropriately.

There were systems in place to ensure the safe management and administration of medicines so that people received their medicines as prescribed. We looked at the medication records for a number of people and saw that there were appropriate guidance for staff to administer medication and that staff had signed the Medication Administration Records (MAR) charts as required.

We noted that a record of the room temperature where medicines had been stored had been kept so that the temperature was monitored to ensure that all medicines were stored at the recommended temperature to maintain their effectiveness. There was a safe system for the disposal of medicines that were no longer required and records of all medicines that had been disposed of had been kept so as to maintain an audit trail.

There were five people living in the home who have learning disabilities and complex needs. We noted that some people had gone out with staff and others who had stayed behind were supported on one to one basis. We looked at the duty rotas and found that it was difficult to establish which staff had actually worked on the day. We were told by the manager that the rotas did not represent the staffing in the home. It was therefore not possible to say if the home was staffed effectively on each shift. However, on the day of our inspection, there were sufficient numbers of staff on duty to support people in meeting their needs. Staff told us that each person was supported on a one to one basis when they stayed at home and received two to one staff support when they were out in the community. The manager said that there was an on call system and when they were short of staff, the on call person would cover the shift.

Requires Improvement

Is the service effective?

Our findings

Staff were not experienced and did not have the knowledge and skills to perform their roles and responsibilities effectively.

There were five people living in the home who have complex needs that they required support on a one to one basis from staff when they were in the home and two to one staff support when they were out in the community. They needed staff who were experienced, knowledgeable and skilled in caring for people who presented behaviours that may cause injury to themselves or others. Staff said that the training they had for supporting people whose behaviour may cause injuries to others was to de-escalate the situation and calm the person down. However, we observed in care records and from talking to staff that people's behaviour had not been managed appropriately. We found that one member of staff who worked a night shift on 24 September 2014, did not have the relevant training. The staff member had no previous experience of working with people with complex needs. We found that staff who had no experience were not able to access training and support to help them provide care to the people within the service. Some training had been delivered however, the provider told us that they were not monitoring the training to ensure it was effective and that staff had understood what had been delivered to them. The provider was putting the people who used the service at risk of unsafe and inappropriate care by not ensuring that staff were suitably trained, skilled and knowledgeable in regards to the people they cared for.

This was in breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not access the support of appropriate health care professionals in the management of their behaviour that may cause injury to others as staff and the provider had not sought advice guidance or made referrals for people who displayed behaviour that was difficult to manage. For example, we saw evidence that one person frequently attacked staff members. We noted from the care records for that person that no specific guidance to manage such incidents had been provided for staff. We also noted that expert advice had not been sought from other health care professionals such as a Psychologist to support the person in the management of their behaviour. Therefore, proper steps had not been taken to ensure that the person was protected against the risk of receiving unsafe or inappropriate support.

This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that because people exhibited behaviour that may cause injury to others, they had received training in the use of restraint as a last resort. Staff had also received training in Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) . This legislation is used for decision making on behalf of the people who did not have mental capacity and that the decisions taken would be in their best interest. Staff were able to describe what the MCA meant to people they cared for and showed an understanding of recent case law in relation to DoLS.

The service was complying with the legal requirements of DoLS. The DoLS provide a legal framework to deprive someone of their liberty, it is in their best interests or is necessary to keep them safe. The manager said that currently, there were four people who had an authorised DoLS , the provider had acted in accordance with the law when making the requests for authorisation under the MCA 2005.

People's dietary needs were met. We saw that people had a variety of nutritious meals provided for them. We observed lunch and noted that people were support appropriately with their meals and not rushed. People were given plenty of drinks and one person was able to ask for more drinks when they needed. We noted from the care records that people's weight had been monitored so that they maintained their wellbeing.

People had access to other health care services so that they received appropriate support to maintain good health. A record of all health care professionals had been kept with the prescribed treatment.

Requires Improvement

Is the service caring?

Our findings

People's privacy and dignity had not been always respected. Staff confirmed that on occasions male staff had provided personal care to female residents. We noted from the minutes of a recent staff meeting promoting poor practices such as male staff were able to provide personal care to female residents. We found from staff records that a male member of staff had raised concerns that they had been asked to provide personal care to a female resident and that they both felt this was inappropriate.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff we spoke with said that they ensured that people's privacy and dignity was respected. When attending to their personal care they ensured that the doors were closed and curtains drawn. They also said that they ensured that people were dressed appropriately before coming out of their rooms. We observed staff knocked on people's door and called for them before entering. Staff confirmed that respecting people's privacy and dignity had been discussed in their induction programme.

Staff were aware of maintaining people's confidentiality and that they said they disclosed information about people to those who were involved in their care such as their parents, GP and other health care professionals.

We saw staff treated people with kindness and in a calm and considerate way. They interacted with them in a caring, respectful and professional manner. Although people were not able to communicate verbally, we observed they understood when staff spoke with them. Staff demonstrated they knew each person, their likes and dislikes and their behaviours and were able to provide care and support appropriately. For example, one member of staff told us, "We could tell whether something was bothering them or someone had upset them by the way they behaved." At lunch time, we saw one person threw their plate on the window half way through their lunch and we noted that staff responded in a professional manner and calmed the person down by talking to them. On another occasion, one person suddenly started to pace in the lounge and a member of staff calmly asked them whether they wanted some assistance.

Due to their learning difficulties, people were unable to make decisions for themselves. However, some people were able to understand day to day routines and simple instructions when staff spoke with them so that they would be able to make a decision. For example, they were able to let staff know whether they wanted to go out or stay in and whether they were hungry or wanted a drink. We saw staff used Makaton sign language, showed people pictures and symbols to help them make decisions for themselves. However, each person had their parents or relatives involved in the decision making process except for one person who was being supported by an advocate. The parents we spoke with confirmed that they had been involved in the decisions about the care and support people received and that they visited the service regularly and were able to discuss any specific issues with the staff.

Requires Improvement

Is the service responsive?

Our findings

We looked at the daily records of three people and found that they had not been attending their planned activities. We spoke with the manager about this and they said that there were times when people said 'no' when asked and thus they did not go out or joined their activities. We noted that people did not have a varied and stimulating day. For example, people who did not go out, either stayed in the lounge/dining room or spent most of their day in their bed. The staff we spoke with said that they encouraged people to spend more time away from the home during the day.

People's care records provided evidence that their needs were assessed before they came to stay at the home. Information obtained from the assessments and reports from other health care professionals had been used to develop each person's care plan. However, we noted that the care plans had not been reviewed since 2012 and therefore up to date information about them was not available to staff. We looked at a care plan for one person which stated that they used continence pads during the night. However, we saw that this person also needed this support during the day. Therefore, people's changing needs had not been reflected and updated in their care plans so that their needs were met appropriately.

This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care plans provided information about the individual's history, their preferences and interests as well as their risk assessments, support plans and a health support plan. The health support plan was a document that provided an overview of the person's health care needs which they took with them when they attended appointments to their doctors or other healthcare professionals. We saw staff had kept daily notes on how people spent their day, any problems or difficulties they had experienced. Information from the daily notes was shared with staff starting the next shift so that they were kept up to date about each person to maintain continuity of care. However, the daily notes had not been checked and evaluated by the senior staff as required. We brought this to the attention of the manager who confirmed that they expected the senior staff to sign when checked and that they would discuss this issue in their staff meeting.

We noted that one person went to the local college with the support of the staff to attend a music session. Staff told us that they planned each person's activities including a monthly discovery group which people were accompanied to visit. Some people accessed the local community facilities such as the local shops and cafes.

The service had a complaints procedure. There had been three complaints received this year. We found that one of the complaints related to an allegation of bruising sustained by one person. The local safeguarding team carried out an investigation the allegation was not substantiated. Another complaint was received because they could not access to the service after a tree had fallen down and had blocked the road. The third complaint had been made by a relative that their [relative] was unable to attend to their swimming sessions because there was no staff cover provided and therefore the person had stayed in the home. We noted that they complaints had been dealt with in accordance with home's complaints procedure. The manager said when people who used the service were unhappy and had any issues or concerns, these were dealt with on the day as part of their management and support plan.

Requires Improvement

Is the service well-led?

Our findings

Appropriate actions had not been taken following incidents involving people and staff to ensure that it did not happen again. There was no learning culture or reflective sessions to ensure that staff had a debriefing following an incident particularly when these were of serious nature. We saw evidence that on seven occasions during a period of three months, staff had been attacked by a one individual. The staff members were in distress and in discomfort. However, there were no systems in place to support staff when involved in such incidents nor other systems to analyse and develop a strategy to reduce the recurrence of incidents.

The audit systems in place were ineffective. The medicine audits had failed to identify that controlled drugs were not stored as required by the Misuse of Drugs Act. Health and safety checks carried out had also failed to identify the risks of electrical wires exposed as stated under 'Safe' section at the beginning of this report. There were no systems in place to audit care plans so that people's needs were met appropriately.

We saw that a survey was completed in 2014 to assess the quality of the service provided. This had been given to each of the people using the service, however the survey had been completed by members of staff on behalf of people using the service and no concerns had been raised. Therefore, it was not possible to establish whether the survey was truly reflective of the peoples' views. There was no other mechanism for getting people's feedback to help with making improvements in the quality of the service.

This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that there was an emphasis in promoting and supporting people to maintain their independence as much as possible. Although they had been facilitated to access local community facilities, this had not happened regularly. There were systems in place to seek the views of those acting on behalf of people about the quality of service. A parent's forum was held annually and staff meetings were held regularly. We were told that parents phoned regularly for updates on the progress of their sons and daughters to ensure that their needs were met.

We found that the staff were reserved and cautious when we talked to them. For example, one member of staff said that they had not seen any incident when a person had attacked a member of staff. However, we found from the incident records that the member of staff we spoke with had been supporting the person at the time of the incident and had called for help. The response we received from the staff members was short, particularly about their training, the activities provided for people and incidents. When we had asked about the issues relating to male staff attending to personal care for female service users, they said that this did not happen. However, we noted from the minutes of the staff meeting held on 06 August 2014 that the registered manager had told staff that this practice was acceptable. We had also received information that this was a current practice which had not been challenged.

There was a staffing structure which gave clear lines of accountability and responsibility. There was the registered manager who had overall responsibility for the management of the service supported by a number of team leaders. They were aware of their responsibilities to notify the Care Quality Commission as required by legislations. The team leaders took the lead role in running the shifts and ensuring that people's care and social needs were met. We were told that information about people was shared with staff at the start of each shift to ensure that continuity of care and support was maintained.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person did not assess the risks to people's health and safety to prevent them from receiving unsafe care.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not have appropriate systems in place to seek the views of people and act on their feedback.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The premises where care and treatment was delivered had not been suitably maintained.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider did not ensure that people’s dignity was respected.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider did not take appropriate action to ensure that people received appropriate person centred care that was reviewed regularly.
	The provider did not deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of people.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider was not operating robust recruitment procedures in order to ensure that all the required checks had been carried out before staff were able to work with people.

The enforcement action we took:
We issued a Warning Notice and the provider was required to become compliant with these requirements by 1 December 2014.