Dame Hannah Rogers Trust

Hannahwood Transitions

Inspection report

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Ratings

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

Overall summary

Hannahwood Transitions is a care home providing personal and nursing care for up to 23 younger adults with physical disabilities. Accommodation is provided within five purpose built bungalows. Hannahwood Transitions is situated on the same site as Dame Hannah Rogers's school. On the days of our inspection 20 people were living at the home.

This inspection was unannounced and took place over two days on 13 and 15 October 2014. At our last inspection in August 2014 we found breaches of regulations relating to how people's care and welfare needs were met, supporting workers, assessing and monitoring the quality of service provision and records. The provider sent us an action plan to tell us what improvements they were going to make. During this inspection, we looked to see if these improvements had been made. Improvements had been made and the regulations were now being met.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

There were sufficient numbers of staff on duty to support people safely and ensure everyone had opportunities to take part in a variety of activities inside and outside of the home.

Staff received a comprehensive induction programme. Staff had completed appropriate training and had the right skills and knowledge to meet people's needs.

People had access to healthcare professionals to make sure they received appropriate care and treatment to meet their complex health care needs. Staff followed the guidance provided by professionals to ensure people received the care they needed to remain safe.

Care plans included detailed information about people's daily routines and needs. One staff member said "We add to the care plans as we find out something or get to know people; this really helps us provide good care". However, it was not evident when reviews took place. The registered manager commented the review process would be formalised as part of the development of care plans and the lead nurse would be responsible for monthly reviews.

Many people who lived in Hannahwood Transitions were not able to fully verbalise their views. People used a range of communication tools. For example, people had electronic communication aids attached to their wheelchair; others also used signs and symbols to aid communication and choice making. Staff had the knowledge of the various communication aids used by people to support them effectively.

Staff were happy working at the service and told us the management team were supportive, kept them informed, listened to them and acted on any concerns raised.

People's medicines were managed safely. People received their medicines as prescribed and received them on time. Staff understood what the medicines were for. People were supported to maintain good health through regular access to healthcare professionals, such as GPs, social workers, occupational therapist and district nurses.

Staff understood their role with regards to the Mental Capacity Act (2005) (MCA) and the associated Deprivation of Liberty Safeguards (DoLS).The MCA is about making decisions and what to do when people cannot make decisions for themselves. Applications were made and advice was sought to help safeguard people and respect their human rights. All staff had undertaken training on safeguarding adults from abuse, they displayed good knowledge on how to report any concerns and described what action they would take to protect people against harm. Staff told us they felt confident any incidents or allegations would be fully investigated.

There were effective quality assurance systems in place. Any significant events were appropriately recorded and analysed. People knew who to contact if they needed to raise a concern or make a complaint. Feedback was sought from people living in the home, relatives, professionals and staff. Evaluation of incidents were used to help make improvements and ensure positive progress was made in the delivery of care and support provided by the home.

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?

Good

This service was safe. There were sufficient skilled and experienced staff to support people.

Staff had a good understanding of how to recognise and report signs of abuse. Staff were confident any allegations would be fully investigated to protect people.

Medicines were administered safely and staff were aware of good practice.

Is the service effective?

Good

The service was effective. People received care and support to meet their individual needs.

Staff had the training, knowledge and the skills to carry out their role effectively.

Health and social care professionals were contacted when required so people received appropriate care and treatment.

The registered manager had received training in the Mental Capacity Act and the associated Deprivation of Liberty Safeguards. Staff understood the requirements of the act which had been put into practice.

Is the service caring?

Good

The service was caring. The staff respected people's privacy and dignity.

The staff knew people well. People were able to make choices about their day to day lives and the service used a range of communication methods to enable people to express their views.

People were involved in the care they received and supported to make decisions.

Is the service responsive?

Good

The service was responsive. People received individual personalised care.

People had access to a variety of activities within the service and the community. People were supported to take part in activities and interests they enjoyed.

There was a complaints procedure in place that people and their families knew how to use.

Is the service well-led?

Good

The service was well led. There was an experienced registered manager in post who was approachable.

Staff were supported by the registered manager. There was open communication within the staff team and staff felt comfortable discussing any concerns with the registered manager.

Quality assurance systems were in place and regularly monitored to drive improvements to the service.

Hannahwood Transitions

Detailed findings

Background to this inspection

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

The inspection was unannounced and took place on 13 and 15 October 2014. The inspection was carried out by two inspectors.

Prior to the inspection we reviewed all the information we held about the service, and notifications we had received. A notification is information about important events, which the service is required to send us by law. Following safeguarding concerns the service had been sending us weekly action plans to let us know what they were doing to ensure people using the service remained safe.

During the inspection we met with everyone who lived at the care home and observed how staff interacted with and cared for people. Many people had limited verbal communication and were unable to tell us about their views of the service. We spent time in the communal parts of the home observing how people spent their day as well as observing the care being provided by the staff team. We looked at how people were supported during lunchtime, how people were supported to transfer from their chair to bed and how people received medicines. We reviewed six care records, staff training records, and records relating to the management of the service such as audits and policies and records relating to the running of the home and how the service was monitored.

We spoke with four people who used the service and relatives of three people. We spoke with the registered manager, the deputy manager, a nurse and 16 care workers. We contacted five health and social care professionals involved in caring for people who used the service.

Is the service safe?

Our findings

At our last inspection in August 2014, we were concerned people were not protected against the risks of receiving care or treatment that was inappropriate or unsafe. The provider did not have a system in place to review and update people's support arrangements, or to consider people's safety in the event of a fire. The provider sent us an action plan detailing how they would make improvements. At this visit we found our concerns had been appropriately addressed.

Hannahwood Transitions provided a safe and secure environment to people. Since our last inspection the provider had installed additional lockable gates surrounding the bungalow. Each bungalow had a secure keypad entry system with an easy exit system in the event of a fire. Visitors were required to sign when entering and leaving each bungalow. Staff checked the identity of visitors before letting them in. Smoke alarms were tested and evacuation drills were carried out to help ensure staff and people knew what to do in the event of a fire. All care plans included up to date personal evacuation plans.

Care plans detailed how individuals needed to be supported to be kept safe. People let staff know when they felt unsafe and the communication profile held within the plans, explained how people would do this. Care plans included risk assessments related to the environment and specific needs of individuals.

Relatives felt their family members were safe. Comments included; “The staff have to know […] well to keep her safe. The staff know her well and follow all the guidelines in her care plan” and “[…] would communicate if she was unhappy, we have had no concerns. “The staff are always very consistent, have the same approach when dealing with behaviours.”

Training records showed medicines training had been delivered to staff via on-line training. The deputy manager confirmed additional medicines training was in the process of being arranged for all staff to attend. Staff had completed training in chest management for people who may have difficulty breathing or had respiratory issues. This supported people who were prescribed oxygen for emergencies. One staff said; “I have done medicine training and more training is planned” and “I have done training to help me look after people in an emergency- I feel confident helping people”. The home provided a nurse 24 hours a day to assist staff and support people’s complex health needs.

Relatives said; “The service provides excellent medical back up and equipment” and “Medically I can’t fault them. When […] was unwell they had a nurse with them at all times”.

The provider had safeguarding policies and procedures in place. Posters were displayed in each bungalow and provided information and contained contact details for reporting any issues of concern. Staff were fully aware of what steps they would take if they suspected abuse and were able to identify different types of abuse that could occur. A staff member told us, “If I have any concerns I report them to my line manager and be confident they would do something.” Staff knew who to contact externally should they feel their concerns had not been dealt with appropriately. Staff said, “We have an open culture here- this helps to keep people safe”.

Staff spoke with people when providing care, giving them information about potential risks, for example when moving and handling people. They respected and acknowledged people's wishes and independence. One relative said; “The staff respect that the people they support are young adults and that they should be allowed to try new things and take risks”.

People identified at being of risk when going out in the community had up to date risk assessments in place. For example, where people required emergency medicines whilst out in the community. People had risk assessments and clear protocols in place for the administration of medicines. Staff were provided with information and training on how to manage risks for individuals to ensure people were protected. Incident recordings confirmed the service reviewed incidents and made changes to ensure incidents did not re-occur. For example, following one incident the service had introduced a new gastrostomy recording form to ensure people did not receive wrong food. Medicine cabinets had been installed in individual’s bedrooms to reduce the likelihood of future errors in medicines administration. There were safe medicines procedures in place and medicines administration records (MAR) had been fully signed and updated.

A relative informed us they had been contacted by the registered manager to discuss their relative’s financial

Is the service safe?

affairs. The registered manager had discovered, during a financial audit, a potential risk to their relative. The relative stated they had not considered the risk and were "Glad that this had been pointed out to them". This issue was discussed during the inspection with the registered manager, who told us the risk had been removed. Staff had been advised during team meetings about the policies relating to the management of people's personal monies. The service had introduced finance passports for people. This held information on how people's money was managed.

The registered manager and deputy manager informed us they liaised with a specialist learning disability service to support people who displayed behaviour that could challenge others. Staff told us they managed each person's behaviour differently and this was recorded into individual care plans. The service provided one to one staffing during the daytime for each person and this was evidenced by the staff rotas. Staff told us there were sufficient staff on duty to keep people safe. A senior staff member commented some people needed two to one staffing for some personal care tasks. They said; "The staffing levels work well and we are able to meet people's needs".

Care plans detailed the staffing levels required by a person to keep them safe inside and outside the service. For example, staffing arrangements had been put in place to help ensure a person had two members of staff available to enable the person to carry out an activity in the community safely. There was a contingency plan in place to cover staff sickness and any unforeseen circumstances.

Staff files showed the home had safe recruitment processes in place. Required checks had been conducted prior to staff starting work at the home. For example, disclosure and barring service checks had been made to help ensure staff were safe to work with vulnerable adults.

We obtained feedback from the local authority quality team. This team had requested that Hannahwood Transitions admit a person to their service. The provider gave clear reasons why they could not admit this person. The provider informed them that, due to recent safeguarding and staffing issues, they did not feel they could meet this person's needs safely at this time. This demonstrated that, whilst this may have impacted on the person concerned, the provider had taken responsible action to help ensure they could meet the needs of people they supported.

Is the service effective?

Our findings

At our last inspection in August 2014, we were concerned training arrangements within the service were not sufficient to enable staff to deliver care and treatment to people safely and to an appropriate standard. The provider sent us an action plan detailing how they would make improvements. At this visit we found our concerns had been appropriately addressed.

People received care from staff who had the knowledge and skills to carry out their roles and responsibilities effectively. Staff completed a full induction programme that included shadowing experienced staff. The registered manager and deputy manager told us staff received ongoing training. Staff said; "I am shadowing full time for two weeks - I have also done loads of training" and "I have an induction sheet, which has to be signed off by senior staff".

Staff received regular supervision with their line manager. Team meetings were held to provide the staff the opportunity to account for their performance, highlight areas where support was needed and encourage ideas on how the service could improve. A staff member commented they had opportunities to discuss issues of concern during their one to one supervision, appraisals and at staff meetings.

People had their specific dietary needs met. This was either the consistency of their food or people received their food via a gastrostomy site and included people's likes and dislikes. People had detailed eating plans in place and mealtime routines. We observed staff providing support with people's gastrostomy feed. One staff told us, "I have worked with individuals for some time and understand their needs. They said; "In addition to mandatory training I also completed a competency test before I could undertake the PEG (gastrostomy) feeding". Care plans held a gastrostomy feed regime chart to support staff. Other charts provided information to staff on how to manage care for the gastrostomy site. For example cleaning the gastrostomy site. People's specific routines, equipment required, and risks were documented to provide information to staff in how to assist people.

People spent time with staff in the communal kitchens and were encouraged to make choices and partake in preparing snacks and drinks. People were supported at meal times on a one to one basis as agreed within care plans. We heard staff talking to people about their meal, describing the flavour so that people knew what to expect. Meal times were relaxed and unrushed and people had the opportunity after their meal to have a drink and enjoy the social interaction between staff and other people. People had individual plans, which held risk assessments relating to dietary and hydration requirements. People's weight was monitored and food and fluid charts were completed for people where there was an identified risk in relation to their food and fluid intake. Staff were familiar with the nutritional requirements of these people.

We observed hand-over meetings between staff shifts. Staff discussed changes in people's health needs as well as any important information in relation to medicines or appointments. Care records held health action plans detailing people's past and current health needs as well as details of health services currently being provided. Health action plans helped to ensure people did not miss appointments and recorded outcomes of regular health check-ups.

People had access to local healthcare services and a local GP surgery provided regular visits and carried out annual health checks. When people's needs changed, the staff made referrals to relevant health services for support. Staff consulted with external healthcare professionals when completing risk assessments for people, for example the speech and language therapist (SALT) and the epilepsy nurse specialist. If people had been identified at risk of continued seizures, guidelines had been produced by the epilepsy nurse specialist for staff to follow. Healthcare professionals said that staff kept them up to date with changes to people's medical needs and contacted them for advice. Healthcare professionals also confirmed they visited the home regularly and were kept informed about people's wellbeing. This helped to ensure people's health was effectively managed.

The registered manager understood the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and how to apply these in practice. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. DoLS provide legal

Is the service effective?

protection for those vulnerable people who are, or may become, deprived of their liberty. The registered manager confirmed they were reviewing individuals to determine if a DoLS application was required. The registered manager informed us no one was subject to a DoLS application and people were not restricted from leaving their bungalows. We observed and staff confirmed that people went out to the local community to attend a variety of activities. For example, we saw and spoke with a person who had been for a haircut in the town and someone who had been shopping. We observed many examples of staff seeking people's consent before providing care. For example staff said they encouraged everyday choices if possible, such as what people wanted to wear or eat. Records showed discussions had taken place with people about any possible risks for the person and best interest meetings were held when needed.

Is the service caring?

Our findings

We visited each of the bungalows and all had a relaxed and calm atmosphere. Staff treated people with kindness and compassion. Staff spoke with people when they provided care and asked people if they were happy and comfortable with the support being given. We observed staff providing care and support to one person. The staff member told them what they were doing at every stage and ensured the person concerned understood and felt cared for.

Relatives told us they were happy with the care and support people received. Comments included; "When the staff talk to […], they always hold her hand, talk with her, not about her"; "The staff encourage choice making, encourage […] to try a wide range of food" and "[…] is always encouraged to be independent, We feel the care is absolutely fantastic". A healthcare professional told us the staff were caring, they supported people well and always kept them informed.

Staff were knowledgeable about the people they cared for. Staff understood how to meet people's needs and knew about people's lifestyle choices in detail. Staff provided us with information on people's likes, dislikes and the type of activities they enjoyed. Monthly meetings were held between people and their keyworkers which helped to develop positive relationships.

People were supported to express their views and be actively involved in making decisions about their care, treatment and support. Care plans were personalised and reflected people's wishes. For example, one care plan recorded; "I like to choose what I am going to wear. I like to look in the mirror". The staff confirmed they supported this person to choose their clothes. Staff said they got to know people through reading their care plans, working alongside experienced staff members and the person themselves. Staff knew what was important to the people they supported such as their personal care needs and about people that mattered to them. This helped ensure the views and needs of the person concerned were documented and taken into account when care was planned

People had access to individual support and advocacy services, for example Independent Mental Capacity Assessors (IMCA). One care plan stated "I speak to my psychologist if I am feeling low". One person requested to speak to the registered manager. We observed staff respected this person's wishes and made arrangements for them to speak to registered manager.

People were able to spend time with their families in private rooms if they wanted to. Staff understood what privacy and dignity meant in relation to supporting people with personal care. For example, one staff said, "We keep doors shut and main doors locked. We always maintain people's privacy and dignity". Staff demonstrated their respect for people's privacy by knocking on bedroom doors and ringing door bells to gain access to each bungalow.

People who were not able to communicate verbally were supported to make choices. We saw one person was given the choice of two drinks; they used their hand gestures to make their choice. Staff knew how people communicated and encouraged choice when possible. For example, people had photos/symbols to help them communicate decisions about activities they would like to take part in during their day. One staff member said, "People are given the time to make their feelings known."

Is the service responsive?

Our findings

At our last inspection in August 2014 the service did not have clear systems in place to regularly review and up-date people's support arrangements. We found that information about people's needs were disorganised and lacked detail. The provider sent us an action plan detailing how they would make improvements. At this visit we found our concerns had been appropriately addressed.

New care plans had been completed with information about the person's needs and how they chose and preferred to be supported. People had guidelines in place to help ensure their specific health and care needs were met in a way they wanted and needed. Care plans included a 'getting to know me' section. This told a brief story about the person their life, their interests and how they chose and preferred to be supported. Staff stated plans had been put together over a period of time by the staff who worked with the person who knew them best. The registered manager said the review process for care plans would be formalised as part of the development of the new care plans and the lead nurse would be responsible.

People's social history was recorded. This provided staff with guidance as to what people liked and what interested them. People led very active social lives and participated in activities that were individual to their needs. We saw people going out throughout the day of our visits. For example, to participate in sessions including computer skills and independent living skills. People took part in individual activities based on their preferences. This included spending time with staff painting and doing art work. One person who was getting ready to attend a pet therapy group said; "Yes, I enjoy it, I hold the animals". Staff told us of regular community activities people attended. One staff member said; "We do a lot of different activities and always go out when we can". Relatives told us; "Our daughter has recently been on holiday with one of her best friends who she also lives with, they loved it" and "They have given […] a quality of life that you and I take for granted. […] has a full, positive quality of life".

People were supported to maintain relationships with family members who visited regularly. People were supported to develop and maintain relationships with people that mattered to them and avoid social isolation.

One relative said they had been impressed by the service and they had a discussion about their relative moving into the service. They said; "The manager listened and spoke with […] about this issue, we then all agreed that this move would improve […] social interactions and opportunities".

People were supported to use a range of communication tools which were regularly reviewed. Electronic aids attached to wheelchairs; pictures, signs and symbols were used to assist with communication and choice making. Staff said plans were in place to install an electronic communication aid to the bed of one person they supported. This meant that staff were responsive to people's communication needs.

The complaints procedure was displayed in a picture format so people could understand it. Complaints had been responded to promptly and thoroughly investigated in line with the service's own policy. Appropriate action had been taken and the outcome had been recorded and fed back to the complainants. People were enabled to share their experiences in different ways through individual meetings, surveys and reviews. Family members were encouraged to make suggestions and to express their views and opinions through informal meetings with the staff team.

Relatives said; "Staff always communicate with us regularly and deal with any concerns or issues we have" and "The managers are always open to suggestions from us, they are responsive and caring". Healthcare professionals said the staff were responsive to people's health care needs and acted quickly if they changed.

Is the service well-led?

Our findings

At our last inspection in August 2014, people were not protected from the risks of inappropriate or unsafe care because effective quality monitoring systems were not in place. The provider sent us an action plan detailing how they would make improvements. At this visit we found our concerns had been appropriately addressed.

Health and social care professionals confirmed to us that communication between them and the provider was good. They told us the service was well led, staff worked well with them and followed advice, and staff provided good support to people.

The registered manager and deputy manager took an active role within the running of the home and had good knowledge of the people and the staff. There were clear lines of responsibility and accountability within the management structure. Staff told us the registered manager was accessible and approachable. They were able to raise concerns and felt concerns would be dealt with. Staff said there was good communication within the team and they worked well together. Staff felt supported. Staff said; “The management are a lot more visible- they always call in to see people” and “We can contact them if we are unsure about anything”. “The manager or deputy visits each bungalow twice a day, usually at the end of each shift”.

Staff had a good understanding of their roles and responsibilities and said they were well supported by the registered manager. One staff member said; “There has been lots of recent changes, lots of opportunities to discuss issues. The deputy manager is always approachable” and “We can go to management whenever we need, and training has increased and improved”.

Monthly staff meetings were held to enable open and transparent discussions about the service, and allow all staff to raise any concerns or comments they had. This updated staff on any new issues and gave them the opportunity to discuss any areas of concern. Staff told us they were encouraged and supported to raise issues.

There was a quality assurance system in place to drive continuous improvement within the service. Audits were carried out in line with policies and procedures. Staff were aware of accident and incident reporting processes and escalated any concerns to the registered manager. The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations. The registered manager kept relevant agencies informed of incidents and significant events as they occurred.

The registered manager undertook audits to check the quality of service provision. This included checking the quality of care records and the quality of supervision given to staff. A representative of the provider said they would continue to keep relatives and other agencies fully informed of their plans for the service.

Feedback from relatives included; “The registered manager and deputy manager have been really supportive, have helped us deal with other agencies”; “Very responsive, we were listened to by the staff and management”; “Management has improved recently”; “The registered manager is open to suggestions, responsive and caring” and “The management team is visible, open, they look at things in the person’s best interest”.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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.

This section is primarily information for the provider

Enforcement actions

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