

Friends Therapeutic Community Trust

Glebe House

Inspection report

Glebe House
Church Road, Shudy Camps
Cambridge
Cambridgeshire
CB21 4QH

Tel: 01799584359
Website: www.glebehouse.org.uk

Date of inspection visit:
04 January 2019
08 January 2019
09 January 2019
10 January 2019

Date of publication:
01 February 2019

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Glebe House is registered to provide care and treatment to people using the service. This includes therapeutic programmes of care designed to support people with their treatment needs. Children and younger people usually stayed at the service for a period of two years, but this could be extended where this was of benefit to the person. The service is a two storey premises located in the village of Shudy Camps in a rural setting. It also has on site workshops, garden facilities, a theatre, sports and recreational facilities as part of people's therapies.

The service is also registered and inspected by OFSTED for younger people receiving educational support. People's accommodation is provided as part of their educational needs.

This announced inspection took place between 4 and 10 January 2019. At the time of our inspection there were 12 people using the service.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our inspection in May 2016 the service was rated as 'Good'. At this inspection the rating for Safe and Well-led had deteriorated to 'Requires Improvement'. This is the first time the service has been rated as 'Requires Improvement'.

Staff were trained in how to pro-actively recognise and report abuse and incidents related to people's safety. They set up and maintained clearly documented evidence of incidents and how they were dealt with. However, the service failed to report safeguarding incidents and allegations to the local authority and the Commission. The providers policy failed to inform staff of the correct reporting procedures and to whom.

The information and guidance for people's medicines was not always detailed and medicines were not always stored safely. This put people at risk of harm.

The provider's policies did not always provide accurate information to staff for responding to incidents. Audits and quality assurance procedures were not always effective in identifying improvements that were needed. Communication with others involved in people's care was not always done promptly and this prevented input into people's care and respond swiftly to people's changing needs.

Staff promoted good hygiene and clean environment standards. Staff and people adhered to good infection prevention and control procedures.

The service remained effective. Skilled and knowledgeable staff supported people with their care and

treatment needs. Staff received training and support according to people's needs. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People were supported to eat and drink sufficiently. Staff supported people to access health care services or enabled this.

The service remained caring. People were cared for and treated with kindness and compassion. People had a say in how much they wanted to be involved in their care. People's treatment and care plans were detailed and gave staff the information they needed. People who needed advocacy support were supported to access this. People's privacy and dignity was respected and promoted.

The service remained responsive to people's needs. People received treatment and care that was person centred. People used technology to access services involved in their care. People's concerns were acted on before they became a complaint.

The registered manager fostered a positive, open and honest staff team culture. People, relatives and advocates had a say in how the service was run. The registered manager and staff team worked well with other stakeholders involved in people's care and treatment.

We found one breach of the Care Quality Commission (Registration Regulations) 2009 and one breach 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 the report.

Further information is in the detailed findings below.

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 had deteriorated to Requires Improvement.

Not all incidents of harm and allegations had been referred to the local safeguarding teams.

The management of medicines was not always safe.

Staff were knowledgeable about safeguarding systems and reporting incidents to the management team.

Is the service effective?

Good ●

The service remained Good.

Is the service caring?

Good ●

The service remained Good.

Is the service responsive?

Good ●

The service remained Good.

Is the service well-led?

Requires Improvement ●

The service had deteriorated to Requires Improvement.

The provider had not ensured we were notified about events that by law we must be told about without delay.

Audits and quality assurance systems were mostly effective, but some opportunities to improve the service were missed.

The registered manager led an open and honest staff team culture.

People and their relatives had a say in how the service was run.

Glebe House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This announced inspection took place between 4 and 10 January 2019 and was undertaken by one inspector. We gave the service 48 hours' notice of the inspection visit because the registered manager can be out supporting people in the community whilst transitioning to more independent living. We needed to be sure that they would be in.

Before the inspection the provider completed a Provider Information Return (PIR). This is information we require providers to send us at least annually. This provides us with information about the service, what the service does well and improvements they plan to make. We used this information to assist us with the planning of this inspection. We also looked at other information we held about the service. This included information from some statutory notifications the provider sent to us. A notification is information about important events which the provider is required to send to us such as incidents that could cause people harm.

Prior to our inspection we contacted the local safeguarding authority and commissioners of the service to ask them about their views of the service. These organisations' views helped us to plan our inspection.

As part of this inspection, we spoke with three people's social workers by phone. On 8 January 2019 we visited the service and spoke with the registered manager, the clinical director, four support workers and two members of the human resources team. We also spoke with four people who used the service. On 9 January 2019 we spoke with two people's relatives by phone.

We looked at care documentation for three people using the service and medicine administration records. We also looked at two staff files, staff training and supervision records and other records relating to the management of the service. These included records associated with audit and quality assurance, accidents and incidents, and complaints.

Is the service safe?

Our findings

The provider's safeguarding policy was not in line with legislative requirement and did not include their local multi-agency procedure for reporting safeguarding matters. Staff, therefore, did not follow this procedure. A key principle of safeguarding is to report incidents and allegations to the relevant local authority safeguarding team who have a statutory lead role to co-ordinate safeguarding investigations. Staff did not fully understand roles and responsibilities in the safeguarding process.

Staff were suitably experienced in recognising signs or allegations of safeguarding issues and how to report them internally. From the safeguarding records we looked at, three incidents had not been reported to the local authority safeguarding team. A social worker told us they had not been informed of any incidents and the local safeguarding team confirmed they had not received any safeguarding concerns from the service in the past 12 months. This meant the provider did not receive oversight and guidance, where it may have been needed, to ensure their safeguarding responsibilities were being carried out effectively and to keep people safe.

The service did not follow current and professional guidance about the management of medicines in relation to storage, opening medicine containers and over the counter guidance. Staff did not monitor the temperature of medicine storage conditions to make sure they were stored in line with manufacturers recommendations and remained effective, particularly in the months when there was a period of extreme heat. Where medicine containers needed to be dated when opened, this had not been done and staff, therefore, would not be aware of when the medicine had expired.

One person told us they took their medicines when needed, as well as over the counter remedies including Paracetamol. There was no guidance or protocol for staff to refer to in relation to the safe management of over the counter medicines for minor ailments and be clear of any potential risk such as interaction with prescribed medicines.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The clinical director told us they would act on these matters.

Staff assessed people's medicine support needs and some people were supported and enabled to manage their own medicine.

People were supported by enough staff who knew how to keep people safe and promote their independence. People felt safe at the service. One person said, "I feel safe with the staff here at Glebe House. I can ask for support at any time and I get it." A social worker told us that staff promoted people's safety, enabled them to take risks which were safe and that there were enough staff with the right skills to keep people as safe as practical. A relative told us that whenever support was needed for their family member to undertake a home visit, this was provided.

Risks to people were assessed and managed well so that people were protected and included. Risk

assessments were in place for people with associated behavioural support plans and preventative strategies to support staff to minimise risk. Care plans gave staff important information on how to recognise potential triggers that increased a person's anxiety and related behaviours and the strategies needed to prevent or reduce their anxiety. One relative told us that since using the service, their family member was safer because they were now more able to deal with their own emotions.

The provider continued to follow an effective and robust recruitment process to help to ensure new staff employed were of good character and suitable to work with people who were vulnerable. Pre-employment checks were carried out which included a criminal record check, previous employment references and photographic identity. One staff member told us that as part of their interview, the registered manager had explored their reason for any gaps in their employment and their character and values.

There were policies, systems and procedures in place to keep the service clean. Each person had responsibility for keeping their room clean and tidy, as well as washing their clothes. One person said, "I have learned a lot about hygiene." Communal areas were kept clean and or preparing food. The service had been awarded the highest food standards rating from the Food Standards Agency.

There were systems in place for reviewing and investigating safety and safeguarding incidents internally. From these we saw lessons were learned and action taken as a result when things did not work quite so well. For example, changing the security arrangements for the service's WiFi code by adding additional security to the staff room door as people had managed to access this by breaking into an office. In addition, there had been successful engagement by people in their therapies due to staff's learning from previous events. This was through the daily community therapy meetings where people felt able to share what impact their actions had and how they were to change their behaviours.

Is the service effective?

Our findings

Glebe House provided an integrated programme of assessment, therapy and transition for young adults with complex needs. Their physical, mental health and social needs were assessed together with their associated care and treatment needs to ensure the correct support and therapeutic input. People's transition to the service was completion of a five-week therapeutic programme before a placement decision was made.

People voluntarily moved into the service and were involved in making decisions with support from a key worker. This is a member of staff with responsibilities for a person's care and support, including being a first point of contact. New people to the service were supported by a peer who were successfully near the end of their therapeutic support programme and residential placement. A social worker for one person told us their therapeutic programme had changed their life for the better.

The needs of people using the service were met by staff who had the right competencies, skills, knowledge and attitude to carry out their role and responsibilities effectively. A social worker told us that staff "definitely have the right skills". Staff received training that helped them to develop the skills they needed to meet people's needs effectively such as positive behaviour support, a supportive and positive approach that explores strategies and methods to reduce incidence of behaviour that is challenging. Staff were also taught non-physical break away skills to enable them to manage conflict and protect themselves and others from distressed behaviour. Other training subjects included autism, food hygiene, first aid, fire safety, and equality and diversity. Staff were supported to maintain their current skills and gain new ones through refresher training, best practice guidance and reflection on current practice.

People were supported to eat a healthy balanced diet which met their nutritional needs. People had achieved a healthy weight through a combination of healthy eating and exercise. We observed that the meal times were an occasion where staff and people ate together. This fostered life skills and gave people a sense of being part of a community. The lunchtime experience was one of much conversation and laughter. One person said, "The food is great. I can ask for something else if I give the staff notice. We also grow our own fruit, herbs and vegetables which we cook and eat." Another person who was living more independently did their own shopping with staff and told us, "It is easy to pick the wrong items and [staff] help me to budget and buy only what I need so I have food all week."

Staff supported and enabled people to access relevant health professionals when needed to maintain their general health and wellbeing. One relative told us that management staff kept them well informed about their family member's health and any changes or appointments such as, a dentist or optician. Treatment plans demonstrated people were supported to see a GP. One person told us they could do this for themselves, they said, "I trust my key worker but if it is something personal, they respect that." The provider used a multi-disciplinary team approach to people's health and treatment. This ensured a more coordinated approach to people's healthcare and resulted in better outcomes. For example, mental health support and GPs worked together to review prescribed medicines. Records showed people's attendance at health appointments and the outcomes of these.

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 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 and other legislation.

We checked whether the service was working within the principles of the MCA. The registered manager was aware of the process to adhere to should any person require care that was in their best interests, such as with decisions about health care.

For people under the age, or mental age of 18, there is accompanying legislation. For example, the Children Act 2004. Most people using the service came under parental control or those acting on the person's behalf including the judiciary.

Staff described to us the principles of the MCA applied to children between the ages of 16 and 18, and adults. For example, respecting people's choices, supporting people to make a choice and letting people make unwise decisions where this was safe. One person told us they had decided with full support from staff, to not take one of their medicines. The clinical director said they had been pleasantly surprised at the positive outcome. The person told us, "I feel much better than I expected." Regular reviews were in place to monitor people's decisions about their wellbeing. One staff member told us, "I help people to understand their decisions and their consequences and how these may change in the future." The clinical director was knowledgeable about when to apply to the local authority to deprive people of their liberty, where living at the service was in the person's best interests.

Is the service caring?

Our findings

Staff provided people's treatment and care with kindness, compassion and empathy. One person told us that the staff team did their best to ensure their care was as attentive, considerate and caring. One social worker told us that the person they had commissioned care for at the service would, "definitely tell me if they felt in any way worried or unhappy." A relative said, "I can't believe how settled my [family member] has become since moving to Glebe House. It is a warm, homely and welcoming environment for younger people and adults. It hasn't all been plain sailing, but staff there persevere."

Our observations throughout the day showed that staff listened to what each person had to say and responded with thoughtfulness. Staff considered the best way to ensure people felt they mattered. Staff never passed people by without offering their time for a conversation or discussion about the person and how they were. People lived fulfilling lives.

People's care and treatment plans included each person's life history and who was involved in deciding the best way to support the person. Staff used this information to support people and care for them impartially. We sat in on one of the three daily community meetings where staff gave each person the opportunity to describe their care and if anything needed to be changed. One person told the community members of their experiences the earlier evening and how staff had helped them to defuse a situation. Appointed people took turns to chair this meeting, contributed to the agenda and ensured each person's comments were listened to.

People were supported to access independent advocacy services if needed, as well as regular contact with social workers and relatives if this was safe and appropriate. On arrival at the service, people were given a booklet about how to access any external support, as well as the staff and management team. This helped people understand their treatments and therapies and how it was intended to help people live more independently. One person told us they could call their family member every day by phone.

People had privacy when needed and staff respected when people needed time to reflect and be on their own. One staff member described the importance of respecting people's personal care needs, as well as being a shoulder to lean on when needed. One person told us they could choose how much family involvement they wanted, when this was and how it was provided including over the phone or supported visits to go back home. Another person said, "I am respected by the staff team. I have had to earn that and knowing they trust me means a lot." Where people had communication needs staff were patient and gave time to listen and, where needed, care plans were written in alternative formats such as easy read with pictures.

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. People, or those with authority to act on their behalf, social workers, healthcare professionals and other professionals contributed to each person's plan of care. This ensured the person's care plan fully reflected their physical, mental, emotional, social and educational needs and how these were to be met.

People were supported to follow their interests, take part in social activities, including the wider community, learn and develop new skills, training and completing their education. These included, musical performances, restoring old vehicles, gardening and growing plants, vegetables and fruit, forestry management and business management. One person had grown various plants and other people restored used furniture and sold these items. The profits were reinvested into the service [The Friends Therapeutic Community Trust] to benefit others using the service.

There were facilities for people to undertake programmes of education or spend time relaxing, playing video games, listening to music and doing sporting activities. One person said, "We grew grapes and tomatoes last year and they were delicious." Another person told us how much they had enjoyed learning to drive. One person as a result of this support, passed their driving test as part of their transition to independent living.

People were supported to maintain contact with relatives and close family members where this was in the person's best interests and safe. One relative said, "The [provider] came to visit us and we were all involved in what was best for my [family member]. They would tell me if their needs were not being met. It has been rewarding to see how they have progressed and changed the way they think about life and their actions and behaviours." As part of people's therapy, the provider used a recognised model of care which included democracy, communalism and reality confrontation. This model of community support helped people reflect and contemplate on all aspects of their lives and behaviours.

Concerns were responded to before they became a complaint. Systems were in place to protect people from any potential discrimination should they ever wish to complain. People had access to advocacy support should they need help to complain. One person told us that they would speak with their key worker if they had any concerns.

Where people had raised concerns these were acted on. This included situations where some people had overstepped the boundaries of their care they had signed up to. For example, changes being made including changing a person's daily routine. A relative said that because of regular contact with their family member, they would know straight away if there was a need to complain. The registered manager and management team monitored concerns for any potential trends or themes and took appropriate actions to drive improvement. For example, on one occasion a person needed an increase in their one to one care and support time, and on another a person needed to be given the opportunity to explain their actions.

The service did not provide people with end-of-life care or treatment. However, the provider had processes in place to contact relevant health professionals, should this need ever arise. Others who could be involved

in people's care could include social workers and relatives as well as any advocacy or religious support.

Is the service well-led?

Our findings

The provider had not ensured that we were notified about events that by law we must be told about without delay. This related to three incidents we found had not been reported to the Care Quality Commission (CQC). These events had occurred in the past 12 months and included those resulting in harm of a person using the service and allegations of harm. The provider's policy did not give staff relevant guidance about the incidents that must be reported to CQC without delay. This limited our ability to alert other organisations should this be needed and prevented us from identifying trends that the provider might need to deal with. The registered manager told us they would review their knowledge of reporting adults safeguarding incidents and update their policy for reporting these.

This was a breach of Regulation 18 of the Care Quality Commission (Registration Regulations) 2009.

There were comprehensive systems and governance in place, and good practice was identified and shared with other professionals and regulators. This included those associated with children's care. However, other elements of the providers governance systems were not effective and not all policies accurately reflected the reporting of incidents correctly. Quality monitoring systems had not identified shortfalls in the management of medicines and safeguarding incidents. Where audits of medicines administration records had taken place, they had not identified these shortfalls. This also meant that there were missed opportunities to improve the service when needed. The lack of effective oversight also meant that the chance was missed to work with other stakeholders who should have been involved in people's care and support.

A consistent theme throughout our inspection was how complimentary people and staff were about the support they received from the management team. One person told us that they were soon to be moving to independent living and this success had been down to the staff team helping them deal with their emotions by providing coping mechanisms. One staff member said, "The [registered] manager has an open-door policy. I have regular support and time to reflect on my work. It can be quite a challenging job at times but I can ask for help. Debriefing situations helps understand what could be done differently next time." All staff we spoke with shared a view of being open and honest as this what was expected from people. One staff member told us that if needed they would not hesitate to report any poor care. The provider's policies supported this approach.

The registered manager led by example and there was an expectation for all staff team to support the provider's values of respecting people and actively engaging in people's therapies. Staff promoted the service's values daily by creating a person-centred culture that involved people, was compassionate and promoted people's independence. This culture was embedded. One staff member told us that their supervisions and daily debriefing sessions helped them to gain a greater insight into why people did what they did and what could be changed for the better. The staff member said, "All the support from management is about being positive but also having clear boundaries in place which people needed to respect."

The registered manager and management team were aware of the challenges they faced with some people

using the service who had more complex needs. To address these matters, the provider continued to work with other professionals including psychologists, psychiatrists and research organisations who specialized in community support services. They also attended local children's safeguarding board meetings to share good practice and learning. The registered manager said that they were getting back on track after the Christmas period and people were settling in to their routines. The registered manager also told us that, if needed, they would challenge the decisions made by other professionals if this had the potential to have a negative impact on people's therapies.

People had a say in how the service was run, felt valued and listened to, and could speak with staff at any time. This could also be done in private and confidentially. In addition to regular contact with the staff and management team, the provider sought people's relatives and other professionals' views as a way of driving improvement. The majority of feedback was positive including people who appreciated the enhanced support within their programme of support. Another person highlighted their sense of the respect and celebration of diverse cultural backgrounds which was experienced through their placement. The provider had also identified a need to avoid any potential clash with other survey questionnaires such as, from OFSTED. This was planned to gain a greater understanding of what the service did well or if any improvements were needed.

Regular staff and management team meetings took place and these created an opportunity for staff to share learning. Discussions in meetings reminded staff of their responsibilities, including data protection legislation. One staff member said, "We have regular meetings to discuss each person and the progress they are making or where we need other strategies. We need to have boundaries to help people manage their time in a meaningful way. This helps people to think ahead and plan their time." People had ownership of their decisions.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider and manager had not ensured we were told about events we are required to be without delay. This prevented us from alerting other authorities that could be involved in people's care.
Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always managed as well as they could have been, people were at risk of harm.